Research Report

An Examination of New York State's Integrated Primary and Mental Health Care Services for Adults with Serious Mental Illness

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Preface

This report describes the RAND Corporation's examination of approaches to integrated care for adults with serious mental illness (SMI) implemented by New York state community mental health centers. The purpose of the project was to generate information that will help state policymakers streamline the adoption of strategies for improving the overall wellness and physical health status of people with serious mental illness by making primary medical services available in, or coordinated by, staff in settings where the population already receives mental health care. To do this, RAND characterized, compared, and contrasted three new and ongoing integrated care approaches implemented by community mental health centers operating in the state. These were:

1. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Primary and Behavioral Health Care Integration (PBHCI) Grants program;

2. New York state's Office of Mental Health (OMH) Medicaid Incentives for Health Physicals and Health Monitoring clinics; and

3. New York state Medicaid Health Homes.

Three questions guided this research:

1. What are the *shared and distinctive features* of approaches to integrated care for adults with serious mental illness implemented by community mental health centers operating in New York state?

2. What *policies or strategies* at the initiative/program level, clinic/organization level, and provider/clinical level appear to facilitate or impede implementation, operation, and sustainability of each program type and overall?

3. What *innovations in mental health clinics' approaches to integrated care* implementation, operation, and sustainability are developing, or are already operating in New York state?

Data for this project were collected by RAND through a series of nine site visits (including interviews and focus groups with administrators and mental health, primary care, and case management providers, as well as adult consumers with serious mental illness) and surveys of mental health clinic administrators and associated professionals providing or coordinating integrated care.

Our report describes the results of this research. RAND also provides recommendations to state policymakers, clinical care providers, technical assistance providers, and researchers in

order to further develop approaches to integration available to mental health clinics in New York state serving adults with serious mental illness. As such, this report will be of interest to national and state-level policymakers, health care organizations and clinical practitioners, consumer advocacy organizations, health care researchers, and others responsible for ensuring that individuals with serious mental illness receive appropriate preventive and primary health care services.

RAND's examination of New York state's integrated primary and mental health care services for adults with mental illness was sponsored by the New York State Health Foundation, grant number 2013-0409. Kelly Hunt was the project officer. The research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.

Abstract

The poor physical health of adults with serious mental illnesses, such as schizophrenia, bipolar disorder, and major depression, is a public health crisis. Greater integration of mental health and primary medical care services at the clinic and system levels has the potential to reduce this disparity. In New York state, there are several ongoing initiatives that promote integrated care for adults with serious mental illness, provided or coordinated by community mental health center staff. State policymakers may use information about the strengths and limitations of each initiative in order to promote the adoption of the approaches with the greatest promise. In this report, we examine three ongoing initiatives operating in the state. The first two initiatives (the Substance Abuse and Mental Health Services Agency [SAMHSA's] Primary and Behavioral Health Care Integration [PBHCI] Grants program and New York state's Office of Mental Health [OMH] Medicaid Incentives for Health Monitoring and Health Physicals) are designed to provide varying intensities of primary and preventive health care services colocated within mental health clinics. The third initiative (New York state's Medicaid Health Homes) reflects a different and potentially complementary approach in which physical health care services are coordinated within a network of community providers by case management staff.

Data for this project were collected by RAND through site visits and surveys of mental health clinic administrators and associated professionals. Results showed that PBHCI grantees developed infrastructure that supported a broad scope of primary and preventive health care services in the mental health clinic setting; these broad changes (including staff trainings, for example, to accommodate shifts in work flow) appeared to contribute to clinicwide culture shifts toward integration and shared accountability for consumers' "whole person" health. However, many PBHCI-supported services may not be financially sustainable after the grant period ends. Clinics participating in the Medicaid Incentive tended to implement only those services for which they could bill (i.e., screening and monitoring of physical health conditions), which resulted in newly identified consumer physical health care needs but did not help consumers to connect to physical health care services. Finally, while administrators and providers were optimistic that Medicaid Health Homes have potential to improve access to care for adults with serious mental illness—for example, through improved information sharing and networks of collaborating providers—the newness of the initiative made it difficult to assess the degree to which Health Home networks would meet these goals. Questions about the long-term financial sustainability of Health Homes also remain. We conclude our report with recommendations to state policymakers, clinical providers, and technical assistance providers, and with recommendations for future research, all designed to strengthen New York state's integrated care initiatives for adults with serious mental illness provided or coordinated by mental health clinics.

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Executive Summary

This report describes the RAND Corporation's examination of approaches to integrated care implemented by New York state community mental health centers for adults with serious mental illness. The purpose of the project was to generate information that will help state policymakers streamline the adoption of promising approaches to improving the overall wellness and physical health of people with serious mental illness by making primary medical services available in or coordinated by staff in the mental health settings where this population already receives care. To do this, we characterized, compared, and contrasted three integrated care initiatives operating in the state. From this information, we generated recommendations to state policymakers, clinical providers, and technical assistance providers, as well as suggestions for future evaluation to further strengthen initiatives ongoing in New York state.

Background

Adults with serious mental illness have a wide range of medical, behavioral, social, and other service needs (see Table E.1). Consequently, comprehensive care for this population is best achieved by a system of care in which providers of multiple types work together to ensure that all of these needs are met. In this report, we focus on a modest, but critical, piece of this systems and services puzzle: the integration of primary medical and mental health services.

Table E.1. Needed Services for Adults with SMI

Behavioral Health	General Medical	Psychosocial
Pharmacotherapy	Preventive care	Wellness
Psychotherapy	Acute medical/surgical	Case management
Substance use services	Chronic disease management	Social services (housing, transportation)
Crisis management	Specialty care for complex conditions	Economic
	Laboratory	Peer
	Pharmacy benefits	
	Dental	

We focus on the integration of primary medical and mental health services for adults with SMI because the excess morbidity and mortality in persons with SMI is a public health crisis. Compared with people without mental illness, individuals with SMI (e.g., schizophrenia, other psychoses, bipolar disorder, and severe depression) have higher rates of chronic medical conditions, including hypertension, diabetes, obesity, cardiovascular disease, and HIV/AIDS;

higher frequency of multiple general medical conditions; and more than twice the rate of premature death resulting from these conditions (Kelly, Boggs, and Conley, 2007; Mauer, 2006; Parks et al., 2006; Sokal et al., 2004; Saha, Chant, and McGrath, 2007; Laursen et al., 2013).

Numerous factors contribute to the excess burden of general medical conditions among persons with SMI, including low levels of self-care, medication side effects, substance abuse comorbidity, unhealthy lifestyles, and socioeconomic disadvantage (Burnam and Watkins, 2006; CDC, 2012; Druss, 2007). Within the health care system, attention is focused on barriers to care that result from the organizational and financial separation of behavioral and general health care sectors. These barriers, it is widely believed, contribute to disparities in access to and the quality of general medical care for people with SMI (Alakeson, Frank, and Katz, 2010; Bao, Casalino, and Pincus, 2013; Druss, 2007; Horvitz-Lennon, Kilbourne, and Pincus, 2006). Consequently, integration of care, in particular the integration of primary care into mental health settings, has become a focus of several state and federal policy initiatives.

Some different perspectives on and approaches to integrated care are reflected in three recent initiatives promoting the integration of primary care and mental health services for adults with SMI being implemented in New York state. These include:

1. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Primary and Behavioral Health Care Integration (PBHCI) Grants program

2. New York state Office of Mental Health (OMH) Physical Health Incentives for Health Monitoring and Health Physicals clinics

3. New York state Medicaid Health Homes.

Additional detail about each of these initiatives is provided below.

PBHCI

SAMHSA's PBHCI service grant program is intended to improve the health status of adults with SMI and/or co-occurring substance use disorders by making available an array of coordinated primary care services in community mental health centers and other community-based behavioral health settings. PBHCI grantees receive up to $500,000 per year to enhance screening and coordinate access to primary care services, including four required program features:

1. Screening/referral for needed physical health prevention and treatment
2. Developing a registry/tracking system for physical health needs/outcomes
3. Care management
4. Prevention and wellness support services.

The PBHCI grants program provides a solution to the one-time costs associated with establishing a new program of integrated care through finances to support infrastructure

development (e.g., renovations to space), and other administrative tasks (e.g., data and reporting, evaluation). It also provides short-term (grant period) financing for other nonbillable services such as peers and wellness services that may be of particular value to consumers.

Since the start of the PBHCI initiative in September 2009, SAMHSA has awarded eight PBHCI grants to clinics in New York state. At the time of this report, more than 100 PBHCI grantees have been awarded, with another cohort (of unknown size) scheduled for funding in fiscal year 2015.

Medicaid Incentive

The New York state OMH Medicaid Incentive is designed to encourage the provision of primary care services in mental health clinics using a market incentive mechanism. Through this mechanism, clinics add primary care services to their operating certificate, thereby expanding their billable scope of practice. New Medicaid billing codes were introduced for this purpose, and to qualify to use these codes, clinics had to first apply to OMH for permission and demonstrate that they had the personnel and facility resources to provide the services. Clinics could be approved at two levels of care intensity: A low-intensity level defined as *health monitoring*; and a high-intensity level that includes both health monitoring and *health physicals*. At both levels, the Medicaid Incentive program removes some barriers to providing physical health services in settings where adults with severe mental illness interact with the health care system most frequently. Under this program, physical health services are reimbursed on a fee-for-service basis, do not require referral, and can be billed on the same day as a mental health service. How providers and consumers perceive this shift in practice is one of the questions that we address in this report.

Medicaid Health Home

New York state Medicaid Health Homes are integrated networks of diverse health care providers designed to provide seamless multidisciplinary care to patients with complex medical needs. Health homes are managed by lead organizations, generally large health care provider agencies. Care for individual patients is managed by community-based organizations that have subcontracted with the lead organization to provide care coordination services. The care coordinators work with the network of health care providers and community providers of services such as supportive housing, legal assistance, and food assistance to provide comprehensive, integrated care to health home enrollees. New York's State Plan Amendment (SPA) prioritized the highest-risk Medicaid beneficiaries for enrollment (446,000 individuals), focusing on individuals with SMI and chronic medical conditions. Health Homes are designed to facilitate consumer access to care through coordination of services at the system level, within a network of existing providers. This is in contrast with the programs described above that aim to integrate care at the setting level, within behavioral health clinics.

About this Report

The aim of this report is to describe the operation of each of three ongoing approaches to integrated care for adults with serious mental illness implemented by community mental health centers operating in New York state. In particular, we emphasize the mental health clinic perspective on integrated services either offered or coordinated by the mental health agency, because the mental health clinic is often the gateway through which adults with SMI access the health care system (Bao, Casalino, and Pincus, 2013).

Readers should note that this is a descriptive, qualitative study in which we aim to learn from the experiences of clinics that were strategically selected due to their efforts to provide primary care services to adults with SMI. The study is not an evaluation of mental health–based primary care overall or of any of the three models that we examined, and we cannot address evaluative questions about impacts of initiatives on outcomes or total health care costs. Instead, this study is designed to highlight institutional, regulatory, and design features that help or hinder current policy efforts in New York state, on the presumption that the goals and strategies of these policies will remain a priority for policymakers.

Readers should also note that while the perspectives of substance use providers are not systematically included in this report (substance use services are overseen by a separate, third regulatory agency in New York state and are therefore beyond the scope of this project), we strongly encourage decisionmakers to consider how those services can also be integrated for adults with serious mental illness, given their high rates of comorbidity and considerable impact on the outcomes of any mental health or medical care that consumers receive.

Three specific questions guide the research in this report. These are:

1. What are the *shared and distinctive features* of approaches to integrated care for adults with serious mental illness implemented by community mental health centers operating in New York state?

2. What *policies* or strategies at the initiative/program level, clinic/organization level, and provider/clinical level appear to facilitate or impede implementation, operation, and sustainability of each program type and overall?

3. What *innovations in mental health clinics' approaches to integrated care* implementation, operation, and sustainability are developing, or are already operating in New York state?

Methods

Data for this project come from two sources: visits to sites investing in innovations in the delivery of mental health–based integrated care, and surveys of mental health clinics and affiliated providers.

Site visits

RAND staff visited a total of nine mental health clinics throughout New York state. Sites were selected with three goals in mind: (1) geographic diversity, representing New York City as well as rural and urban upstate areas; (2) representation of all three of the integrated care initiatives available to clinics currently ongoing throughout the state; and (3) active and innovative efforts to improve the provision of primary care services to their adult clients with SMI. We strategically visited innovative sites in order to identify solutions and other promising practices from clinics, administrators, and clinicians who are actively working on the challenge of mental health–based integrated care. As a result of this selection strategy the clinics in this study are not representative of mental health clinics in the state and may be biased toward clinics that have more effective service delivery systems overall. Site visits were conducted between October 2013 and March 2014.

The overarching goal for the site visits was to gain a broad understanding of how primary care services fit into the mental health service delivery system. During visits, we toured facilities and conducted interviews with as many different types of clinic staff as time and scheduling allowed. We also met with groups of consumers at most sites. Topics covered during site visits included (but were not limited to) clinic structures, range of services provided, composition of the care team, target population and consumers served, clinical work flow, Health Information Technology (HIT), use of data for practice management and continuous quality improvement, clinic culture of integration, and sustainability, as well as policy impacts, barriers to integration, and promising integrated care practices being developed by the clinics.

Surveys

We also fielded two separate yet complementary surveys to (1) mental health clinic administrators, and (2) providers affiliated with mental health clinics providing or coordinating integrated care. The sampling frame included all OMH licensed Article 31 behavioral health clinics in New York state. All the PBHCI grantee clinics were included in the sample. A stratified, random sample of remaining clinics was selected from a list of all licensed Article 31 clinics in the state provided by OMH. The sample was selected to have equal numbers of clinics with and without OMH Medicaid Incentive licenses and to be equally distributed across regions of the state. Survey topics were the same as those covered during site visits.

The final clinic administrator survey sample included data from a total of n=22 mental health clinics, located in four out of five regions of the state, and all three integrated care initiatives examined in this report. Provider survey data came from n=34 unique providers (from across the participating clinics) and included primary care, mental health, and case manager/care coordinator positions. The survey response rate to the provider survey was acceptable for a web-based survey (69 percent). Although survey respondents broadly represented the array of clinics

and providers meant to be included in the study, the overall response rate to the clinic survey was low (20 percent).

Results

Research Question 1: Shared and Distinctive Features

Shared

All participating mental health clinics were Health Home affiliated and typically affiliated with more than one Health Home. Clinics of all types offered on-site screening and monitoring of physical health conditions, and at almost all clinics, mental heath care records were maintained in an electronic format; few of these records, however, were integrated with records from primary care or other physical health care providers. Case manager/care coordinator notes were almost always maintained in a separate electronic system, as well. Providers of all disciplines described closer collaborative relationships at clinics offering a broader scope of physical health services on site (even when the scope of these services was limited, as in Medicaid Incentive clinics), suggesting that providers who work together in the same space may have more opportunities to build trust and respect related to the provision of integrated care. Overall, providers from all clinic types reported that they perceived that their integration efforts were improving consumer access to physical health care services and outcomes.

Participating clinics were quite diverse, varying in location (urban/suburban/rural), size, and other features, with notable differences between clinics participating in each integrated care initiative. All of the PBHCI clinics were located in the metropolitan New York City area (including all the PBHCI clinics in NYS that did not participate in this study). The PBHCI clinics were larger, serving more adults with SMI than other clinic types, and more likely to be situated within agencies with a medical hospital affiliation (potentially facilitating access to primary and other medical services, plus other infrastructure to support physical health care such as HIT). PBHCI clinics were more likely to report using registries to support clinical care (note that clinical registries were a core component of PBHCI). Importantly, PBHCI clinics were more likely than other clinic types to have obtained (on their own or via a partner organization) a Department of Health (Article 28) license to provide comprehensive, on-site primary care. Licenses and availability of grant funding likely affected staff membership on the care team: PBHCI clinics were more likely to employ case managers, peers, and wellness specialists. PBHCI clinic administrators described a broader role for case managers than at other clinics, and perhaps relatedly, PBHCI clinic staff also reported greater success enrolling consumers in integrated care initiatives, including Health Homes.

In contrast, Medicaid Incentive clinics tended to be smaller, free-standing (non-hospital-affiliated) entities. Medicaid Incentive clinics provided only the limited scope of primary care services (health monitoring, health physicals) permitted by their licenses. Participation in the

incentive did not typically alter clinic infrastructure (e.g., record systems, physical space) or membership on clinics' care teams. For instance, primary care services were often provided by existing mental health staff (e.g., psychiatric nurses provided the primary care). Medicaid Incentive clinic administrators also reported a comparatively narrow role for case managers in consumers' overall care.

Finally, mental health clinics participating in Health Homes but not PBHCI or the Medicaid incentive program were varied, including academic medical center–affiliated clinics and free-standing clinics of varying resources, capabilities, and size. Among these clinics, overall, we observed that participation in the Health Home did not alter the clinic's scope of practice. As intended by the program, participation in Health Homes appeared to be associated with increased reliance on case managers and networks of agencies to get consumers access to primary care.

Research Question 2: Policies

Implementation and Operation

Overall, clinic staff reported that state-level investments in integrated care infrastructure, such as Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), the Regional Health Information Organizations (RHIOs), and state drug databases, were helpful for characterizing and tracking consumer status and care outside of their immediate system of care. Several differences across integrated care initiatives were also observed.

Although the PBHCI grants were not a panacea (e.g., the grants did not relieve provider shortages in underserved areas), the clinics that received PBHCI grants were able to apply considerable financial resources to develop and implement their programs of integrated care, including pursuing comprehensive licensing options, hiring peers, supporting interdisciplinary case conferences, and more. The scope of services supported by the grants (including staff trainings regarding their expanded role at the clinic) helped to create an integrated care culture.

In contrast, integrated care culture change was not observed in the clinics that were using the Medicaid Incentives, despite the fact that the administrations of these clinics were committed to the same goal of whole person consumer care (albeit many of them with fewer resources to support integration from the outset). Specifically, Medicaid Incentive services were provided as part of a clinic routine, e.g. "seeing the nurse," and not as part of a multifaceted (e.g., primary care, wellness, peers) shift in approach that involved multiple providers and an overall culture change. For instance, aside from those who were providing the specific Medicaid Incentive services, staff did not receive trainings on the importance of, or steps toward addressing consumers' physical health care needs. Overall, we found that consumers placed little value on the Medicaid Incentive–supported services because services did not address their desires for improved access to acute treatment services for physical health conditions such as headache or flu.

Health Homes represent a different approach to integration, focusing on coordinating care within a network of providers rather than developing a new or modifying a specific, existing clinical setting. The Health Home has the potential to complement any scope of primary care offered in, or coordinated by, the mental health clinic (including PBHCI and the Medicaid Incentive) because case managers are meant to be able to link consumers to any needed additional services elsewhere within the network. Health Homes' potential, however, is not yet clear since the program is in its early stages, and medical providers expected to accept SMI adult referrals contacted by Health Home case managers were often unaware that the program existed at all. Similarly, whether Health Homes truly have capacity to meet consumers' social service needs that may moderate their willingness/ability to follow through with primary care treatment (e.g., transportation, housing) requires investigation.

Characteristics of Successful Programs

We observed several clinic features that appeared to be associated with program success across initiatives. First, mental health clinics benefitted from close relationships with community programs, such as Personalized Recovery-Oriented Services (PROS). Community programs helped to create a care "center" that increased consumer contacts and trust with integrated care providers, plus increased the overall convenience and consumer-reported desirability of physical health services. Such clinics were also able to use existing groups to offer wellness services, contributing to centerwide shifts towards a culture of health and shared accountability for mental and physical health care. Second, clinics benefitted from using new consumer information and quality data systems (PSYKES, RHIOs). Clinics described having increased access to consumer information about hospitalizations, discharges, and other significant events that wasn't previously available, thereby increasing their ability to do timely follow-ups and target case management resources to consumers most in need. Third, successful clinics were eager to take advantage of the information-sharing privileges associated with the Health Home. While the newness of some of the Health Home networks made the ultimate impact of this feature difficult to assess, clinics anticipated that information sharing within the Health Home would streamline their current processes for connecting consumers to services not available on site while also supporting continuity of care. Fourth, as with many health care reforms, we observed that institutional champions were often credited for enabling clinics to implement integrated care in institutions and communities where it otherwise did not exist. In this case, champions were often individuals with particular expertise in health systems and finance who could navigate a complex policy context and leverage or flex existing resources to accommodate integration. Relatedly, some of these champions created legacies sustained through the creation of training programs (e.g., residency tracks for Medicine in Psychiatry; new programs in integrated care at nursing schools) at local institutions that funneled interested and qualified providers to integrated settings in the community.

Remaining Challenges

Administrators described challenges integrating services at the systems (e.g., OMH-DOH, payers, and others) and clinic levels (e.g., mental health and primary care providers). At the systems level, challenges to integration included access to licenses that facilitated integrated care, maximizing existing infrastructure (e.g., space, HIT, payers), and the financial sustainability of integrated care. While administrators from all clinic types reported the belief that forthcoming managed care programs would impact sustainability (potentially in positive or negative ways), in general, financial concerns were different across clinic types. Within PBHCI clinics, administrators were concerned about the sustainability of wellness, peer, and care management services following the end of the grants. In some cases, administrators expressed concerns that payers were not keeping pace with policy and that claims for legitimate integrated services (e.g., mental health and primary care services delivered on the same day) were being rejected, requiring significant administrative effort to secure reimbursement. At Medicaid Incentive clinics, sustainability concerns were more moderate and related to perceptions that current reimbursement rates defrayed but did not cover health physicals and health monitoring costs and were not available to support any related medical needs such as follow-up on referrals to physical health treatment. Finally, sustainability was a major concern among Health Home clinics and providers. In particular, concerns were widespread that changes in reimbursements (e.g., expiration of legacy rates) and subsequent increases in caseload may reduce the quality, intensity, and clinical impact of the services that case managers can provide.

At the clinic level, clinics of all types reported concerns related to information sharing among providers on the care team, including those at affiliated agencies, and accessing appropriate and timely social services (particularly transportation and housing) to enable consumers to take advantage of integrated primary and behavioral health offerings.

Research Question 3: Innovations

Clinics of all types developed unique and innovative approaches to the delivery of integrated care. These included innovations in consumer enrollment and engagement strategies, focusing on "bottom-up approaches" such as leveraging existing professional and social networks (e.g., recruiting at health fairs, community events, asking consumers' family members about health care needs) to identify potential Health Home enrollees. They included innovations in work flow, such as weekly, interdisciplinary case conferences and a web-based care coordination platform allowing providers to communicate routinely in a virtual space, including a dashboard and real-time alerts regarding changes in consumer status (e.g., entrance to emergency department, hospitalization, hospital discharge). Case managers using the virtual space also used the platform as a clinical registry, generating lists of consumers with specific identified needs including information drawn from the local RHIO. However, a challenge of this system was that providers

with only a few consumers enrolled in the Health Home were unlikely to use the system, since it required them to go outside of their local EHR.

Clinics also created innovations in the structure and composition of the care team, such as leveraging the experience of peers to model healthy lifestyle changes and engagement in wellness programs, plus creating new positions (i.e., dedicated care coordinator) to maximize staff expertise in medicine and information systems that allowed case management staff to be more active in the field. Some clinics also restructured their care teams in accordance with the Health Home model, putting the case manager at the head of the care team.

Finally, we also observed innovations in sustainability planning in clinics with Article 28 (full primary care licenses; typically PBHCI but also select Health Home clinics) such as opening medical clinics to consumers' family members and care givers, in order to increase census and increase provider opportunities to bill.

Limitations

Our research has several limitations. Briefly, site visits were conducted at a small, select sample of sites and do not represent the large and diverse population of mental health clinics in New York state. The response rate to the project survey was low, limiting the extent to which results can be widely generalized. Perspectives of clinics not participating in integrated care were not included. Finally, since the clinics that implemented each of the integrated care initiatives are likely to differ from other clinics in ways that we were not able to measure, our observational design precludes us from definitively disentangling effects of the models from underlying features of the clinics that implemented them.

Recommendations

Based on our research findings, overall, we recommend that policymakers create initiatives and/or certifications that hold mental health clinics and their partner agencies jointly accountable for core components of integrated care programs, and that accompanying licensing and funding opportunities are coordinated, approved, and ready to be implemented under all relevant New York state agencies so that clinics themselves can implement integrated services that comprehensively meet adult consumers' health care needs. To meet this end, we recommend the following actions or changes:

Recommendations to Policymakers

- *Explore state-level options that reduce administrative barriers to integrated care.* Administrators expressed frustration with the time, expense, and complexity of obtaining licenses (e.g., full DOH Article 28, integrated, co- or dual license) to provide primary medical services in their mental health clinics. As such, policymakers may consider identifying and implementing policy strategies that

further simplify and expedite mental health clinic licenses to provide medical services.

- *Consider different licensing options for clinics that are hospital affiliated or free-standing*. Our research showed that free-standing mental health clinics have less experience and fewer resources for implementing primary care services. As such, policymakers may wish to offer these clinics alternative licensing options that a) require fewer clinic structural changes than a typical primary care clinic, but b) require more investment in creating formal referral networks for primary care services that are not provided on site.
- *Consider special provisions for clinics in rural settings*. Site visits and survey data both showed that rural clinics experience many of the same, but also additional, barriers to care experienced in urban settings. Rural clinics reported more significant provider shortages, longer distances between consumers, clinics, hospitals and specialists, and at the same time, fewer transportation resources. Policymakers may reduce some of these barriers by further incentivizing local providers to care for mental health clinic consumers and by providing (e.g., through case management services) additional resources for transportation to and from medically necessary appointments.
- *Consider whether all mental health clinics are appropriate settings for on-site primary care services.* Given the scarcity of providers who are willing and able to provide primary care to adults with SMI, policymakers may wish to target integrated care resources to settings with the most potential to benefit consumers. Our research tentatively suggests that multiservice settings (e.g., PROS clinics) may show particular promise since consumers already have strong relationships with the agency and its providers, and because these clinics may be better prepared to offer complementary wellness or other services.
- As envisioned by the Excellence in Mental Health Act, *consider promoting a full "package" of services* (see Table E.1) *for adults with SMI through an Integrated Primary Care Behavioral Home.* Our research suggested that mental health clinic membership in the Health Home did not increase mental health providers' behavior toward shared accountability for ensuring consumer access to medical services. As such, policymakers may wish to consider creating a mechanism of shared accountability like a behavioral health home to further incentivize all providers to provide integrated care.
- *Identify and consider implementing strategies that promote joint accountability among all providers caring for, and plans covering, consumers' health care needs*. For example, such strategies would help ensure that primary care providers are jointly responsible for assuring quality for general medical, mental health, and substance

abuse care, and behavioral health (mental health and substance use disorder) providers are equally responsible for those services and general medical care. Strategies to instantiate joint accountability may be applied in training, practice, health plan contracts, performance incentives, and other mechanisms, including clinic and health system culture.

- *Routinely/Formally build in cost/sustainability assessments into evaluation of future integrated care initiatives.* Clinic administrators at all clinic types expressed concern about the sustainability of integrated care, and in some cases, concerns about sustainability made these administrators reluctant to further invest in infrastructure that would support integrated care (e.g., integrating case management records with clinics' own EHR). As such, policymakers may consider collecting cost and sustainability information during pilot tests of integrated care programs to facilitate decisionmaking among system and clinic staff who ultimately determine the uptake of integrated care programs.
- *Consider creating incentives for EHR businesses to create products that interface with available clinical information systems (e.g., partner PC records, case management systems, RHIOs, PSYCKES)*. Clinics reported that a major barrier to information sharing and coordinating care were the costs and burden associated with expanding the functionalities of their EHRs to include information from other available data sources. As such, officials may need to take regulatory steps (such as those described by the Office of the National Coordinator [ONC] to create behavioral health EHRs with greater interoperability) that encourage EHR companies to facilitate this process.
- *Develop a "report card" on the integration implementation agenda to monitor progress over time.* Our research suggests a number of actionable items (e.g., streamlining licensing requirements, suggestions for technical assistance) that could help to facilitate the implementation of integrated care in New York state. As such, policymakers (or other groups, such as consumer advocacy groups) may wish to develop a system for tracking the implementation of these potential improvements over time and report on progress to stakeholders on a routine (e.g., biannual) basis.

Recommendations to Providers

- *Orient staff to the greater purpose of physical health screening and monitoring services, particularly at MI clinics.* Our research showed that the addition of health monitoring and health physicals to mental health clinics did little to improve consumer connections to primary care. It also showed that health monitoring and health physicals clinics did not train their staff to use these services as consumers' gateway to broader medical care. Clinics offering consumers any level of primary

care may have more success improving consumer health if providers are trained on these expectations and provided with means to connect consumers (e.g., through enrollment in the Health Home) to treatment for any identified physical health care needs. Providers should clearly understand the notion of shared accountability for outcomes across mental health, general health, and substance abuse and their role in maintaining that accountability.

- *Assess local PC access barriers and provide solutions.* During site visits, consumers and staff often reported consumer barriers to accessing care that were specific to the clinic setting (e.g., unreliable bus service to the area, primary care doctor not available on the same day as a well-attended group). In order to increase consumer enrollment and use of available primary care services, administrators may consider assessing local barriers to use of available primary care services and then provide evidence-based (e.g., flexible appointment scheduling, walk-ins, same-day) and other practical solutions, as appropriate.
- *Communicate directly with co-providers*. Providers reported (and literature suggests; e.g., Scharf et al., 2014) that care is better integrated when providers communicate about consumer needs on a regular basis. During our site visits, we observed that interdisciplinary case conferences may be particularly useful for planning and coordinating care for complex cases. As such, regularly scheduled opportunities for providers from multiple disciplines to discuss cases are expected to build trust, lines of communication, and may also sustain or stimulate new medial provider interest in serving populations of adults with SMI.
- *Relentless follow-up on referrals.* Administrators, providers, and consumers described access to specialty services as a major barrier to integrated care, and one that may be even more difficult to resolve than connecting consumers to primary medical services. As such, providers making consumer referrals to specialist providers should provide consumers with needed supports to attend these appointments (e.g., reminders, transportation), and ensure that consumers attend these appointments in order to improve consumer health and preserve clinic relationships with valuable and scarce lists of specialists accepting Medicaid and willing to serve their clientele.
- *Consider clarifying/operationalizing the roles and expectations of peer specialists and primary care case managers.* Administrators and providers in this study reported that there were few mechanisms to support peer specialists and primary care case managers. Clearer roles and expectations for peers and primary care case managers might help to stimulate consistent and reliable billing opportunities from payers and ensure that these positions are routinely staffed by individuals with the skills and qualifications needed to maximally benefit consumers.
- *Consider partnerships with Managed Care Organizations (MCOs) to implement integrated care.* Mental health clinics (particularly free-standing clinics) reported low

rates of using data to manage and improve quality of care. MCOs, however, may already be collecting and analyzing data that can be fed back to clinics (particularly those without infrastructure and staff for data analysis) that may be useful for informing practice. Data-driven improvements to care quality may be mutually beneficial to mental health clinics and MCOs.

Recommendations for Technical Assistance Providers

- *Educate MH clinics about different models of integrated care and the accompanying available licensing options to provide integrated care.* New York state is a complex policy environment with many available resources and policies to facilitate integrated care. Clinic and agency administrators may benefit from ongoing technical assistance regarding resource availability, and potential strategies for creating synergies by combining participation in complementary initiatives (e.g., Medicaid Incentive and Health Homes).
- *Provide ongoing support to MH clinics around the use of data for clinical care.* Mental health clinics reported low rates of using data systematically to inform care delivery. Since most clinics already have EHRs, clinics may be able to take advantage of technical assistance that demonstrates the utility of existing (or establishing) registry functions within their EHRs to promote clinical care and perhaps simultaneously satisfy initiative reporting requirements.
- *Investigate barriers to using data systems that support a population health management approach (e.g., PSYCKES, RHIOs) and offer training (or other supports as warranted) to enable use of those systems.* Study participants reported awareness of population health-promoting data systems, yet use of those systems was still low. Technical assistance providers may consider investigating barriers to the use of these systems and then facilitating access to them, as study participants using the systems were likely to report finding them useful for consumer care.
- *Consider providing templates (or lists of key components) of documents that mental health clinics can use to facilitate information sharing across providers on the care team.* Some clinic administrators reported challenges to obtaining consumer consent for information sharing, while others did not. Similarly, some clinics reported difficulties negotiating resource sharing with local primary care partner groups while others had already resolved these issues. As such, technical assistance providers might offer templates for routine documents such as consent forms or memoranda of understanding to enable additional clinics to efficiently and effectively implement integrated care.
- *Consider technical assistance for integrating health care systems approaches with business strategies.* Given the extent of clinic concern about financial sustainability,

clinics may benefit from technical assistance about how to make integrated care financially sustainable within existing business models.

Recommendations for Future Evaluation

- *Monitor and leverage the quality and performance of the Health Home.* Potential benefits from Health Homes were highly anticipated by administrators and providers, including enhanced capacity for information sharing and increased access to services for consumers, such as specialty medical care and housing; however, the degree to which these systems are functioning well in practice remains unclear. To ensure optimal function of Health Homes, policymakers may wish to track consumer flow through essential steps in the care process (e.g., screening, diagnosis, treatment, wellness, aftercare, and follow-up) and provide feedback and incentives to networks based on quality metrics. Similar standards may be applied to case management and clinic-level functions of the Health Home.
- *Assess the degree to which Health Home agencies are participating in networks of care*. Although agencies may be administratively (i.e., "on paper") part of a Health Home, the extent to which they are adequately serving Health Home consumers and participating in the overall coordination of care for those individuals requires investigation. Indeed, a finding of this research was that many providers within Health Home agencies were unaware of the Health Home initiative overall. New network analysis techniques can help Health Homes and policymakers determine how well consumers are linked to services within networks, and how well case managers and case coordinators (CM/CCs) are taking advantage of the scope of services available in their networks.
- *Conduct a formal analysis of the costs, benefits, and sustainability of the current Health Home Per Member Per Month (PMPM) reimbursement rate.* Our research suggests widespread fears about whether the current PMPM is sufficient to cover the costs of quality case management services, particularly because current rates are bolstered by the substantially higher "legacy rates" that are set to expire. Given this upcoming change in reimbursement, policymakers should closely monitor the impacts of reductions in PMPM on quality of care.
- *Explore whether changes in workforce and reimbursement policies help to improve physician participation in integrated care for adults with SMI.* Under the Affordable Care Act (ACA), in 2014, Medicaid fees are now at least equal to Medicare fees. The idea behind the fee increase is to stimulate physician participation in Medicaid and to support physicians who already participate and could expand their Medicaid service. Whether these fee increases are sufficient to stimulate physician participation in integrated care programs (where attracting qualified physicians is often problematic) is unknown.

Conclusions

New York state's mental health clinics are implementing a range of integrated primary medical services for their adult consumers with SMI with support from a range of initiatives. These initiatives provide varying levels of financial and technical support to clinics and staff, and these different levels of investment are reflected in the scope and intensity of services that are made available to consumers, plus the extent of work flow and culture change occurring within clinics. In order to more effectively implement programs intended to better integrate behavioral health and primary care in the state, we recommend that policymakers create initiatives and/or certifications that hold mental health clinics and their partner agencies jointly accountable for core components of integrated care programs, and that accompanying licensing and funding opportunities are coordinated, approved, and ready to be implemented under all relevant state agencies so that clinics themselves can implement integrated services that comprehensively meet adult consumers' health care needs.

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Abbreviations

BMI	body mass index
CM/CC	case manager / care coordinator
CRG	clinical risk group
CQI	Continuous Quality Improvement
DOH	Department of Health
DSRIP	Delivery System Reform Incentive Payment
ED	emergency department
EHR	electronic health record
FFS	fee for service
FMAP	Federal Medical Assistance Percentages
HH	Health Home
HIT	health information technology
HIV	human immunodeficiency virus
LCSW	Licensed Clinical Social Worker
LPN	Licensed Practical Nurse
MH	mental health
MI	Medicaid Incentive
NCQA	National Committee for Quality Assurance
NP	nurse practitioner
NYS	New York state
NYSHF	New York State Health Foundation
OASAS	Office of Alcoholism and Substance Abuse Services
ONC	Office of the National Coordinator
OMH	Office of Mental Health
PBHCI	Primary and Behavioral Health Care Integration
PC	primary care
PCMH	Patient-Centered Medical Home
PH	physical health
PMPM	per member per month
PROS	Personalized Recovery-Oriented Services

PSYCKES	Psychiatric Services and Clinical Knowledge Enhancement System
RHIO	Regional Health Information Organization
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	serious mental illness
SPA	State Plan Amendment
SUD	substance use disorder

Chapter One. Introduction

This report describes the RAND Corporation's examination of New York state (NYS)'s mental health (MH)-based models of integrated primary and mental health care services for adults with serious mental illness (SMI). The purpose of this research is to characterize, compare, and contrast emerging integrated care initiatives provided by or coordinated by mental health clinics operating in NYS. Ideally, this information will enable policymakers to streamline and improve programs offering MH-based physical health (PH) care services to their SMI clientele. At the time of this research, there were three ongoing, integrated care initiatives of this type operating in NYS, targeting adults with SMI. These initiatives, listed below, are the focus of this report.

1. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Primary and Behavioral Health Care Integration (PBHCI) Grants program;
2. NYS Office of Mental Health (OMH) Incentives for Physical Health Monitoring and Health Physicals clinics; and
3. NYS Medicaid Health Homes.

In this chapter, we introduce the problem of chronic physical illness among adults with SMI, the promise of MH-based integrated care, and the models of MH-based integrated care operating in NYS.

Background

Adults with serious mental illness have a wide range of medical, behavioral, social, and other service needs (Table 1.1), and comprehensive care for adults with serious mental illness likely depends on a system of care in which providers of multiple types work together to ensure that all of these needs are met. In this report, we focus on a modest, but critical, piece of this systems and services puzzle: the integration of primary medical and mental health services for adults with SMI.

Table 1.1. Needed Services for Adults with SMI

Behavioral Health	General Medical	Psychosocial
Pharmacotherapy	Preventive care	Wellness
Psychotherapy	Acute medical/surgical	Case management
Substance use services	Chronic disease management	Social services (housing, transportation)
Crisis management	Specialty care for complex conditions	Economic
	Laboratory	Peer
	Pharmacy benefits	
	Dental	

We focus on the integration of primary medical and mental health services because the poor health of adults with SMIs, such as schizophrenia, bipolar disorder, and major depression, is a public health crisis. In addition to their mental health MH conditions, adults with SMI frequently suffer from chronic physical health PH conditions (e.g., hypertension, diabetes, obesity) that reduce their quality of life and life expectancy (Alakeson, Frank, and Katz, 2010). Mental illness is associated with a reduction on life expectancy of about eight years (Druss et al., 2011). Multiple risk factors contribute to the poor physical health of adults with SMI, including side effects of psychotropic medications; unhealthy behaviors such as poor diet, smoking, and physical inactivity; co-occurring substance abuse; and socioeconomic disadvantage (Burnam and Watkins, 2006; Horvitz-Lennon, Kilbourne, and Pincus, 2006). Adults with SMI also face limited access to primary medical care (PC) and preventive health services, and for those who do receive care, the quality of that care is lower than that provided to their non–mentally ill peers (Druss, 2007; Alakeson, Frank, and Katz, 2010).

Community MH providers may be SMI adults' main (or only) point of contact with the broader health system (Bao, Casalino, and Pincus, 2013). However, providers at these agencies frequently lack the resources necessary to diagnose or treat medical conditions, or to coordinate needed services with medical providers (Golomb et al., 2000). As a result, adults with SMI often do not receive general medical services unless they seek medical care in emergency rooms, resulting in inappropriate or ineffective care, and high costs to public health care systems (i.e., Medicaid). In short, efforts by clinicians, researchers, policymakers, and other stakeholders are needed to improve both access to and the quality of PH care services for adults with SMI.

The Promise of Integrated Care

Greater integration between historically fragmented MH and PC systems is expected to reduce health care disparities associated with mental illness (President's New Freedom Commission on Mental Health, 2003; Bazelon Center for Mental Health Law, 2004; Institute of

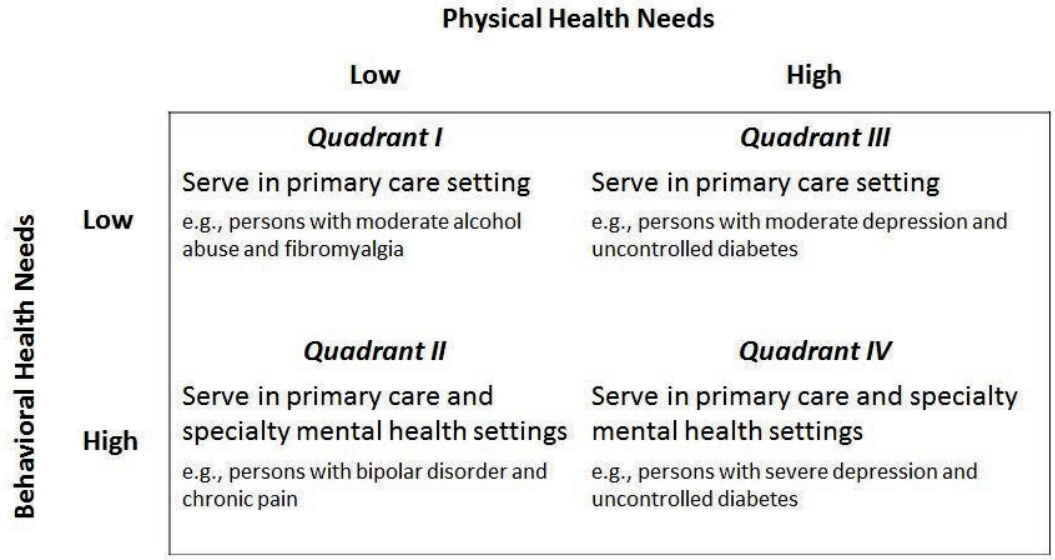
Medicine, 2006) and is now a central component of national health care reform (Rittenhouse and Shortell, 2009; Katon and Unützer, 2013). Broadly, greater integration of MH and PC medical systems is expected to increase consumer access to PC; build collaborative relationships between PC and MH providers; improve capacity for PC providers to distinguish between PH and MH problems; and promote preventive care, such as routine medical screenings and medication checks (Bazelon, 2004).

Integrated care that effectively targets PH problems in adults with SMI also has potential economic benefits to the (predominantly public) payer systems that support the population's care. Costs of care for adults with SMI and comorbid chronic PH conditions can be two to three times higher than for their non-SMI counterparts with same physical health conditions (Melek, Norris, and Paulus, 2014). Moreover, although MH and substance use disorder (SUD) diagnoses are virtually universal among the highest cost Medicaid patients (Kronick, Bella, and Gilmer, 2009), *most of these increased costs come from medical (as opposed to MH or SUD) service use* (Kronick, Bella, and Gilmer, 2009; Melek, Norris, and Paulus, 2014). Current estimates suggest that improvements to the management of SMI adults' chronic PH conditions have the potential to create substantial (5–16 percent) cost savings (Melek, Norris, and Paulus, 2014; Hay et al., 2012). Yet questions remain about whether these estimated gains can be achieved through existing policy interventions and whether MH-based integrated care offers the same potential for savings as the PC-based models on which these estimates were built.

Mental Health Setting Approaches to Integration

Integrated MH and PC care can work in two directions: either (1) specialty MH care is introduced into PC settings or (2) PC is introduced into specialty MH settings. Most approaches suggest that adults with SMI, particularly those with chronic PH conditions, should be served in specialty MH settings based on the hypothesis that populations are best served in the settings where they have established connections with the health care system (Alakeson, Frank, and Katz, 2010; Bao, Casalino, and Pincus, 2013), or by their degree of medical and MH care needs (see Mauer's 2006 Four Quadrant Model of Clinical Integration, Figure 1.1). Indeed, the particular benefits of colocating PC services in MH settings can include simplified SMI patient access to PC, since the population already receives care in MH settings; the opportunity to receive care from providers who are already familiar with SMI adults' complex medical needs and social realities; and availability of PC that can be accompanied by peer-to-peer programs, offering consumers real-life models of healthier living, thereby creating self-efficacy to make health behavior change.

Figure 1.1 Four Quadrants of Clinical Integration Based on Client Need



SOURCES: Mauer, 2006; Collins et al., 2010.

Outcomes

Preliminary studies suggest that integrated care offered or coordinated by mental health settings can lead to improvements in consumers' PH and the quality of care they receive (Butler et al., 2008; Druss and von Esenwein, 2006). For instance, data from a growing number of studies show that consumers served through MH-based integrated care programs have more PC visits, improved attainment of performance measures related to metabolic and cardiovascular risk, and reduced emergency department use (Pirraglia et al., 2012; Druss et al., 2010; McGuire et al., 2009; Saxon et al., 2006; Zappe and Danton, 2004). Recently, the RAND Corporation evaluated the SAMHSA national demonstration of mental health clinic–led integrated care for adults with SMI (PBHCI grants program; one of the approaches included in this report described in detail below). Results of that evaluation showed that the initiative led to improved consumer connections to PC but that connections to wellness services such as smoking cessation and nutrition education programs were more difficult to achieve. The evaluation also found improvements relative to controls in indicators of cholesterol, diabetes, and hypertension, but not in smoking or weight (Scharf et al., 2014). Perhaps limiting the impact of the integrated care interventions was inconsistent implementation of evidence-based wellness interventions (Scharf et al., 2014). In general, studies have not reported changes in MH outcomes as a result of integrating PC into MH settings (e.g., Scharf et al., 2014; Druss et al., 2010).

Challenges and Promising Practices for Mental Clinic Approaches to Integration

Some of the modest outcomes observed in the current literature on integration provided or coordinated by MH clinics may be related to start-up and ongoing operational barriers that

interfere with the quality and intensity of services provided. For example, during the start-up period MH organizations face challenges related to building and establishing working relationships with new partners and agencies (e.g., recruiting and retaining qualified staff; availability of space for PC; new licensing requirements), and changing staff attitudes and culture to promote shared decisionmaking and treatment planning (Scharf et al., 2013). Other challenges may come from expanded use of health information technology (HIT) (e.g., sharing data across provider types and organizations; meeting reporting requirements of new initiatives). Challenges related to staffing and data may also persist beyond the start-up period (Scharf et al., 2013; Boardman, 2006). Program challenges that may emerge after the start-up period include issues related to program capacity and sustainability planning. For instance, programs may experience challenges recruiting and engaging consumers in integrated care, or alternatively, building capacity to meet consumer demand for PC services may be an issue in some settings (Scharf et al., 2013; Boardman, 2006). Program sustainability may be particularly problematic for those whose initial services were funded by one-time grants (Scharf et al., 2014).

Nonetheless, several promising practices are emerging that may facilitate the development and ongoing implementation of MH-based integrated care. For instance, research on the SAMHSA PBHCI grants program showed that clinics can increase consumer use of integrated care by investing in strategies that promote access to services, such as colocated PC services at the MH clinic; offering PC services on more days per week; offering PC services by phone and/or email; and providing transportation to PC appointments (Scharf et al., 2014). Similarly, PC-MH operational integration, such as regularly scheduled PC-MH team meetings, can improve collaboration on treatment plans and shared decisionmaking among PC and MH providers. In addition, consumers may have greater access to a fuller array of integrated services when PC services are provided by a partner agency such as a federally qualified health center (FQHC) that itself offers a wide range of PC services—although connecting consumers to care at partner agencies may be more difficult than connecting them to more limited care on site (Scharf et al., 2014). This latter finding has considerable importance for the field because not all federal and state incentive programs have a single clinic with colocated services as the locus of care. For example, some models focus on care delivered by a network of closely knit providers operating in different locations with a case manager (or other similarly titled coordinator of services), ensuring that all of consumers' health care and social service needs are met. The extent to which these network-focused models impact MH providers and consumers may depend on the extent to which the network facilitates integration of care (see Appendix A for a framework of levels of integrated health care).

Integration in Mental Health Clinics in New York State

NYS has the largest publicly funded mental health system in the country, with behavioral health systems expenditures of about $8.7 billion per year (NYSDOH, 2011). According to the 2011 Office of Mental Health (OMH) Patient Characteristics Survey, the system provides

services to about 175,000 people statewide over a two-week period. About 100,000 of these individuals are seen in outpatient MH clinics, and about 80,000 of them meet criteria for an SMI based on a combination of diagnosis and functional impairment. In 2011, 260,242 individuals received a Medicaid-reimbursed service in a specialty mental health clinic. Consistent with analyses of federal programs (Kronick, Bella, and Gilmer, 2009; Melek, Norris, and Paulus, 2014), nearly half (46 percent) of the total NYS Medicaid expenditures for this group was spent on care for PH conditions.

Despite high levels of PH care need among NYS adults with SMI, the 2011 NYS DOH report suggested that SMI consumers may navigate a system offering little care coordination, even to the highest-need individuals, and little accountability for quality of care or consumer outcomes. The report also linked poor SMI adult outcomes, such as high rates of psychiatric hospital readmission and disproportionately high expenditures on PH conditions, to NYS's fragmented system of care.

Following this report, the integration of PC and MH services became a major focus of NYS's Comprehensive Plan for Mental Health (2012). Since 2011, at least three major initiatives promoting the integration of services for adults with SMI have been rolled out on both small and large scales; others are also under development and pending release (several of these forthcoming initiatives are summarized below). The three initiatives under way in 2013–2014, which will be the focus of the remainder of this report, include (1) the federal SAMHSA PBHCI grants program (large-scale federal program with eight clinics having received grants in NYS); the PBHCI grants provide flexible, up-front grant dollars to MH clinics in order to support an array of infrastructure, care delivery, and administrative activities, (2) an incentive from NYS' Medicaid program (Medicaid Incentive [MI]) to allow for billing of basic PC screening and prevention services for chronic PH conditions in MH settings with no accompanying support for infrastructure development or administration (3) NYS' Medicaid Health Home (HH) initiative, which offers care management and coordination for all Medicaid-enrolled adults with SMI, in which MH agencies can lead the coordination of networks of care. Table 1.2 summarizes key elements of the scope of integrated services supported by each of these three ongoing initiatives, and greater detail about each initiative is provided below. All three initiatives are potentially subject to the same challenges to integration, including a fragmented health care system, licensing requirements, and provider collaboration and communication within and across agencies. The extent to which each initiative offers promising practices to reduce barriers to care is a focus of this report.

Before describing the three integrated care initiatives that are the focus of this report, we acknowledge that an important limitation of this work is that we describe only MH (as opposed to behavioral health) and PC integration. In NYS, substance use disorder (SUD) services are provided by clinics licensed by a separate agency from the OMH. Specifically, Office of Alcohol and Substance Abuse Services (OASAS)-licensed clinics have a different set of administrative relationships with the Department of Health (DOH) and, consequently, with PC provider

agencies. Including all of those interagency relationships is beyond the scope of this report. Nonetheless, while others are evaluating OASAS clinic-based integrated care (Morgenstern, 2014), we strongly encourage decisionmakers to consider how those services can also be integrated for adults with serious mental illness, given their high rates of comorbidity and considerable impact on the outcomes of any mental health or medical care that consumers receive.

An additional challenge of this research is that our research design limits the extent to which we can disentangle the impact of specific integrated care initiatives on clinic function because there is some overlap in the services that they incentivize and support (see Table 1.2). Nonetheless, we provide details about each of NYS's MH-based integrated care programs for SMI adults in the following pages.

Table 1.2. Key Elements of MH-Based Integrated Care Initiatives in NYS

	PBHCI	OMH Medicaid Incentive		Health Homes
		Health Monitoring	Health Physicals	
Program type	SAMHSA grant	Medicaid Incentive	Medicaid Incentive	Care coordination
Earliest care delivery start date	Feb 1, 2010	Oct 1, 2010	Oct 1, 2010	Jan 1, 2012
Number of NYS clinics	8	160	114	48[a]
Infrastructure development	Up to 25% of grant			Some retroactive grants
Administration, data, and reporting	Up to 20% of grant			3% PMPM to lead agency
Physical health services				
Screen, assess, refer	X	X	X	
Diagnosis, laboratory	X		X	
Registry/tracking	X			
Case management/care coordination	X			X
Direct treatment of medical conditions	X			
Wellness / health promotion	X	X		

[a] Number of Health Homes (not clinics), which may include more than one mental health center (current as of April, 2014)

PBHCI

The PBHCI grants program is intended to improve the overall wellness and physical health status of people with SMI by making available an array of coordinated PC services in community MH centers and other community-based behavioral health (BH) settings. In particular, better coordination and integration of PC and MH services, improved prevention, early identification and intervention to reduce chronic diseases, and enhanced capacity to

holistically serve SMI adults (including those with co-occurring SUDs) are expected to lead to better overall health status of the population served.

There are currently 100 PBHCI grantees nationwide and eight of those grants have been awarded to clinics in NYS. All eight NYS PBHCI grantees were funded from the first three waves of grants (i.e., received funds in September 2009 or 2010), which had similar project requirements and funding. Specifically, grantees received up to $500,000 per year over four years to implement four core and six optional program features. The four core features were intended to improve service coordination and access to PC by supporting activities for which there was no funding source. These were

1. Screening/referral for needed physical health prevention and treatment
2. Developing a registry/tracking system for physical health needs/outcomes
3. Care management
4. Prevention and wellness support services.

The six optional program features were: same-day physical and behavioral health visits; colocated, routine primary care services; a supervising primary care physician; an embedded nurse care manager; evidence-based practices for preventive care; and wellness programs. Grantees could also allocate up to 25 percent of the grant for infrastructure development and 20 percent of the grant for performance measurement.

Notably, core program features could be implemented through any strategy proposed by the grantee. Therefore, while programs had some features in common, they also varied widely in terms of how integration was conceptualized and operationalized in practice. For example, grantees could provide the PC services themselves, purchase them through contracts with other providers, or make them available through a memorandum of agreement (MOA) with other providers.

As illustrated in Table 1.2, the PBHCI grants program is meant to directly (financially) support the most comprehensive package of services for SMI adults among the three initiatives considered in this report. It is also the only program that provides resources for infrastructure development, and reporting requirements, and no specification for how providers are to be reimbursed.

The evidence base for the PBHCI grants program is summarized above in our description of challenges and promising approaches to integrated care (see also Scharf et al., 2013, 2014). Briefly, PBHCI grantees have described successes offering integrated services to diverse clientele, and grant services have been associated with some improvements to physical health, including indicators of cholesterol, hypertension, and diabetes (but not weight and smoking). Additional research is ongoing to quantify program costs (Assistant Secretary of Planning and Evaluation contract HHSP23320095649WC). However, there is currently no research available describing the process, outcomes, and unique experiences of PBHCI grantees operating in NYS's unique policy environment. Given the current federal investment in NYS's PBHCI programs

($16 million, plus potential additional investment in the years to come), NYS-specific evaluation of PBHCI is warranted.

Medicaid Incentive

NYS' Medicaid Incentive (MI) program supports the most limited package of MH-based integrated care services among the initiatives described in this report (Table 1.2). Specifically, the MI is designed to encourage the provision of PC services in MH clinics using a market incentive mechanism by which clinics can add PC services to their operating certificate, which defines their billable scope of practice. New Medicaid billing codes were introduced for this purpose, and to qualify to use these codes, clinics had to first apply to OMH for permission and demonstrate that they had the personnel and facility resources to provide the associated services. Clinics could be approved at two levels of intensity of care, a low-intensity level consisting of health monitoring and a high-intensity level that includes both health monitoring and health physicals. At both levels, physical health services do not require referral, are reimbursed on a fee for service basis, and can be billed on the same day as a mental health service.

The health monitoring level allows clinics to bill Medicaid for "continued measuring of specific health indicators associated with increased risk of medical illness and early death." Health monitoring can include but is not limited to assessment of blood pressure, body mass index (BMI), substance use, and smoking cessation, and these services can be provided by a physician, a psychiatric nurse practitioner, a registered nurse, a licensed practical nurse, or a physician's assistant. A distinct code for smoking cessation counseling is included. Services can be billed for individual or group sessions.

The health physical level is a more intensive level of care. A health physical is defined in the regulations as "physical evaluation of an individual, including an age and gender appropriate history, examination, and the ordering of laboratory/diagnostic procedures as appropriate." No more than one health physical can be claimed per year. Health physicals can be conducted by a physician, a psychiatric nurse practitioner, or a physician's assistant. As of January 2013, 160 mental health clinics have received approval to bill for health monitoring, and an additional 114 have received permission to provide coverage for health physicals.

At the time of this report, no evaluations of the MI program had been undertaken, and since the mechanism is unique, there is no reliable evidence base against which to anticipate its impact. This report includes the first publicly available research on this initiative.

Medicaid Health Homes

The federal Medicaid Health Home (HH) program was established as an incentivized option for state Medicaid programs under section 2703 of the Affordable Care Act. HHs are intended to improve integration across physical health, behavioral health, and long-term services and supports for populations with chronic conditions. They are also meant to serve as a mechanism by which to pay for "difficult-to-reimburse" services (e.g., care management, care coordination)

that improve consumer access to and receipt of quality medical care. The HH mechanism was designed to be flexible so that states can develop models that address an array of policy goals using an enhanced 90/10 federal match (FMAP) for the first eight fiscal quarters of the HH benefit. There are currently 22 HH-approved state plan amendments (SPAs), with others under review (CMS, 2014).

New York State's Health Home

NYS's HHs are integrated provider networks managed by lead entities. The HHs serve a distinct population, comprising high users of medical care with complex medical conditions. Care in the HH is provided by existing community providers and coordinated on an individual basis by case managers working in community-based organizations that have subcontracted with the lead entity to provide care coordination services. Care is also coordinated with other network partners that provide nonmedical social support services such as supported housing, legal assistance, and food assistance to health home enrollees. The Care Manager is considered to be the leader of an enrolled consumer's care team.

The SPA prioritized the highest-risk Medicaid enrollees for enrollment (446,000 individuals), focusing on individuals with SMI and chronic PH conditions. NYS's HH SPA was approved in February 2012, and the program itself began in July 2012, rolled out in three distinct geographic phases. NYS's enhanced federal match period ended in April 2014. Table 1.3 provides additional detail about NYS's Medicaid HH program.

Table 1.3. Characteristics of NYS's Medicaid Health Homes

Program Characteristic	Detail
Target population	Individuals with SMI, chronic medical and behavioral health conditions
Providers	Any interested providers or groups of providers that meet state-defined health home requirements that assure access to primary, specialty care and that support the integration and coordination of all care
Enrollment	Auto-enrollment (with opt-out)
Payment	PMPM adjusted based on region, case mix (from Clinical Risk Group [CRG] method) and eventually by patient functional status
Geographic area	Three-phase rollout; phase one includes ten counties.
Date	SPA approved 2/3/12, SPA effective 7/1/12, SPA expires April 2014

SOURCE: HH SPA at a glance 3-19-14.pdf from Centers for Medicare and Medicaid Services (CMS).

To date, there are 48 HHs throughout NYS covering all 62 counties. The 48 HHs are administered by 32 unique lead agencies, some of which operate in multiple regions (Hamblin, Davis, and Hunt, 2014). HH lead agencies include medical health systems, care management and coordination agencies, and behavioral health organizations. Since program inception, the Office of Medicaid has made more than $260 million in payments to HHs to support care management

services for this cohort of patients. In addition to the 90/10 FMAP, NYS has made additional investments to support infrastructure development, workforce training, and practice transformation. Approximately 57,000 Medicaid beneficiaries are currently receiving care management through NYS' HHs, with another 23,000 currently targeted for outreach and enrollment.

More specifically, payment for HH services is made on a per member per month (PMPM) basis at two levels: Outreach and Engagement, which covers efforts to locate and enroll identified consumers in the HH, and Active Care Management, which supports ongoing care for enrollees. Services for Outreach and Engagement are reimbursed at 80 percent of the active care management rate for up to three months following the initial referral from the state (and again after a subsequent three-month period of inactivity). Outreach and engagement of bottom-up referrals (i.e., individuals identified from sources other than state lists) is not reimbursed. Payment for fee-for-service (FFS) enrollees goes directly to the HH, while payment for managed care enrollees goes through the plans, which may retain up to 3 percent of the payment for administrative services. Rates are currently adjusted by region and case mix (Spillman, Ormond, and Richardson, 2012). Specific billable services under NYS's HH are listed in Table 1.4.

Table 1.4. Billable Services Under New York State's Health Home

Service	Definition
Comprehensive care management	An individual patient-centered care plan based on a comprehensive health risk assessment. Care management must be comprehensive, meeting physical, mental health, chemical dependency, and social service needs.
Care coordination and health promotion	The care manager ensures the coordination of services, adheres to treatment recommendations, and generally oversees the needs of the Health Home member. The Health Home provider will promote prevention and wellness by providing resources for prevention and any other services members need.
Comprehensive transitional care	Health Home providers must emphasize the prevention of avoidable readmissions and must ensure proper and timely transitions from one setting to another and follow-up care post-discharge.
Patient and family support services	Individualized care plans must be shared and clear for the patient, family members, or other caregivers to understand. Patient and family preferences must be given appropriate consideration.
Referral to community and social support services	Health Home providers are responsible for identifying and actively managing appropriate referrals and coordinating with other community and social supports.
Use of HIT to link services, as feasible and appropriate	Health Homes are encouraged to use Regional Health Information Organizations (RHIOs) to access patient data and to maximize the use of HIT in the services they provide and in care coordination. Health Home provider applicants have 18 months from program implementation to submit a plan for achieving compliance with the final Health Home HIT requirements.

SOURCE: Spillman et al., 2012.

Early results from NYS HH evaluation are promising, showing that enrolled consumers attend 14 percent more primary care visits and experience 23 percent fewer emergency department visits and inpatient hospital admissions than before the program was put in place

(Moses, Ensslin, and CHCS, 2014). At the same time, NYS's HH program is still in flux. For example, in some regions of the state, HHs are merging in order to create economies of scale around infrastructure development and/or due to lower-than-expected enrollments. Standards for specialized behavioral HHs, targeting adults with SMI, were released in early 2014, which may also influence how the program is refined over time (Joint Commission, 2014). Similarly, helpful recommendations from early evaluation efforts have the potential to further increase program impacts (Moses, Ensslin, and CHCS, 2014). Some of these recommendations include using the HH model to advance policy goals (e.g., enhancing PC capacity and infrastructure; improving coordination and transitions of care; improving integration; defining HH target populations and models to get the greatest impact on outcomes; aligning payment models with policy goals to drive payment modernization); define HH services according to existing, evidence-based models for managing care for complex populations; support strategies that promote provider culture change; and invest in access to real-time data to support effective care coordination. To complement these data and recommendations (which have come from broad evaluation and OASAS-focused reports), we focus our research on the specific perspective of MH clinics leading and participating in NYS's Medicaid HHs.

Other Ongoing or Forthcoming Initiatives

There are several forthcoming opportunities that could further influence NYS MH clinics' approach to, and extent and quality of, integrated services for adult consumers with SMI. A comprehensive review of all of the ongoing initiatives affecting integrated care in New York is beyond the scope of this report and has already been summarized by others (see Spillman, Ormond, and Richardson, 2012). A summary of these initiatives is provided in Appendix B. Briefly, at the federal level, initiatives that could impact MH-based integrated care include the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which requires that group health plans and health insurance requirements (e.g., co-pays, deductibles) and treatment limitations (e.g., visit limits) applicable to mental health and SUDs be no more restrictive than those applied to medical benefits, and the movement toward Accountable Care Organizations (ACOs)—groups of local health care providers that come together to coordinate care and share in the risks and benefits of offering care to a range of health care consumers. Within NYS, a broad transition to MH managed care, also known as Health and Recovery Plans or HARPs, may create greater accountability for the provision of integrated services to adults with SMI. NYS is also implementing the Delivery System Reform Incentive Program (DSRIP), a component of the NYS Medicaid Redesign Team (MRT) Waiver Amendment, featuring a mechanism designed to create integrated systems to coordinate and provide care across systems through collaborations of providers called Performing Provider Systems. Other pilot and grant programs offered by the Centers for Medicare and Medicaid (CMS), including a Patient-Centered Medical Home demonstration, may result in widespread changes to NYS's health care landscape. An integrated OMH-DOH-OASAS license option (referred to as integrated or co-licensing) is currently also

being piloted at ten sites throughout NYS, and clinics participating in this project were included in that pilot; however, only one of these licenses was fully in place at the time this research was conducted. Other pilot applications were still under review. And finally, institutional initiatives promoting integration, such as those being tested by university or other large health systems, may impact whether and how MH clinics support integrated care.

About this Report

Although research is still inconclusive about whether primary care offered on site or coordinated by mental health clinics is an efficient or effective way to deliver primary care to adults with SMI, multiple initiatives in this domain are ongoing or under development. Therefore, NYS needs information about the strengths and challenges of each of these approaches to help state policymakers streamline the adoption of approaches that appear to work best. The aim of this report is to describe the operation of each of three ongoing approaches to MH-based integrated care for adults with SMI (the PBHCI grants, the MI initiative, and NYS's Medicaid HHs) and then to show how policy mechanisms related to MH-based integration are or are not achieving stated goals. Our particular focus is on the MH clinic perspective on integrated services either offered directly in or coordinated by the MH agency for adult consumers with SMI.

Overall, the research described in this report is guided and structured according to three main questions:

1. What are the *shared and distinctive features* of community behavioral health center–based integrated care programs for SMI adults currently operating in NYS?
2. What *policies* or strategies at the initiative/program level, clinic/organization level, and provider/clinical level appear to facilitate or impede implementation, operation, and sustainability of each program type and overall?
3. What *innovations* in integrated care implementation, operation, and sustainability are developing, or are already operating in NYS?

To address these questions, we conducted site visits and key informant interviews with administrators, providers, and consumers at MH clinics throughout NYS, and also surveyed MH clinic administrators and providers in a broader sample of MH clinics. The specific topics covered during visits, interviews, and surveys were aspects of MH-based integration that may be particularly affected by state-level policy. These included the structure of services provided (e.g., colocation; partnerships; care/case management), the range of services provided (i.e., what's meant to be available via the integrated care "program"), composition and expertise of the care team; target population (including recruitment and engagement strategies); clinical work flow; role of data in care and Continuous Quality Improvement (CQI); strategies to create a culture of integration; and sustainability planning. We also queried administrators and providers about the

impacts of specific policies on the implementation of integrated care, plus any innovations that were currently happening or being planned for their clinics' approaches to MH-based integration.

Integration of mental health and primary medical services can look different from different perspectives. Again, we emphasize that this is a descriptive, qualitative study in which we aim to learn from the distinctive experiences of clinics that are strategically selected due to their efforts to provide primary care services to adults with SMI. The study is not intended to be an evaluation of mental health–based primary care overall or of any of the three models that we examined. Since the models were not randomly assigned to clinics and no control group was used, we cannot address evaluative questions such as "Does mental health–based primary care improve the care of adults with SMI or reduce total healthcare costs?" Rather, this study is designed to highlight institutional, regulatory, and design features that help or hinder current policy efforts in New York state, on the presumption that the goals and strategies of these policies will remain a priority for policymakers. In the chapters that follow, we describe visits and interviews at nine MH clinics, representing each of the three integrated care initiatives examined in this report (Chapter Two). In Chapter Three, we supplement our qualitative findings with quantitative survey data from a geographically diverse, more broadly representative sample of MH clinics implementing integrated care. Finally, in Chapter Four, we provide summative answers to the project research questions and offer recommendations to policymakers, clinical providers, and technical assistance providers, and recommendations for research that may streamline the adoption of effective NYS models of MH-based, integrated care for adults with SMI.

Chapter Two. Site Visits

Overview

To observe how the policy efforts described in Chapter One are working across the state, we conducted a series of site visits to MH clinics and HH agencies. Sites were selected from across urban and rural areas of the state with a focus on selecting sites where leadership has taken an active role in developing or advancing PC services for the adults with SMI whom they treat. The goal of the site visits was to describe and compare the experiences of clinics that are pushing the envelope of primary care integration, focusing on factors that, according to the people implementing these programs, have helped or hindered their progress. Consequently, the clinics that were visited are particularly informative with respect to implementation issues because of their distinctive experiences with primary care integration, but they do not represent all behavioral health clinics in the state. Again, it was not our goal to evaluate the programs but to learn about their implementation directly from the people with the most relevant experience. At each clinic, RAND researchers met with staff members and consumers and discussed how the state-level policies were affecting the delivery and sustainability of MH-based integrated PC services.

Methods

Site Selection and Participant Site Characteristics

Site visit clinics were selected with three goals in mind. First, we wanted to include sites across NYS, representing New York City as well as rural and urban upstate areas. Geographic variation is important because the conditions of providing integrated care, such as the availability of primary care providers and transportation options, vary across different parts of the state (see Health Resources and Services Administration, 2014). However, we were limited in our ability to select a geographically diverse selection of PBHCI clinics, since all eight PBHCI grantees in NYS are located in the greater New York City area. Second, we selected sites implementing each of the three integrated care initiatives (PBHCI, MI, HH) available to clinics ongoing throughout the state. While sites implementing PBHCI and MI are all distinct, all sites are involved in HHs (and typically involved in more than one, since multiple HHs are operating in many regions of the state). Third, sites were selected because they were actively working on improving the provision of PC services to their adult clients with SMI. We strategically selected sites that were innovators in this area so that we could learn from their experiences at the front line of institutional change. It is important to emphasize that the purposive selection of clinics is not intended to provide a representative sample of MH clinics in NYS. Rather, the goal is to identify

and learn from cases that are particularly informative because of their distinctive experiences. The lessons learned from these cases are likely to have implications for other clinics operating in similar institutional settings. In total, nine (n=9) site visits were conducted between October 2013 and March 2014. Characteristics of the sites and site visit participants are presented in Table 2.1. The rest of this chapter is structured as a comparison of three clinic types: PBHCI clinics, MI clinics (free-standing BH clinics), and clinics that are part of HH lead agencies.

Table 2.1. Visited Sites and Site Visit Participants

Clinic	Region of State	Rural/ Urban	Program Type	Meetings with Clinic Personnel					
				Administrators	PC providers	Psychiatrists	CM/CC	Consumers	Others
1	NYC	Urban	PBHCI, HH Lead	Y	N	Y	Y	Y	Case conference
2	NYC	Urban	PBHCI, HH Lead	Y	Y	Y	Y	Y	PROS staff; therapists
3	NYC	Urban	PBHCI, HH	Y	Y	Y	Y	N	HIV clinic manager
4	NYC	Urban	HH Lead	Y	N	N	Y	Y	Addiction treatment providers
5	Western	Rural + Urban	HH Lead	Y	Y	N	Y	N	Regional HH partners
6	NYC	Urban	HH Lead	Y	Y	Y	Y	Y	EHR / HIT staff
7	Western	Urban	HH Lead	Y	Y	Y	Y	Y	
8	Central	Rural	MI, HH	Y	Y	N	Y	Y	Day program
9	Central	Rural	MI, HH	Y	Y	Y	Y	Y	

Site Visit Procedures

The overarching goal for each site visit was to gain a broad understanding of how PC services fit into the local MH service delivery system. For site visits to clinics, we toured facilities and conducted interviews with as many different types of clinic staff as time and scheduling allowed. As shown in Table 2.1, we conducted interviews with administrative staff and CM/CCs at all sites and with PC providers, psychiatrists, and consumers at most sites. The site visits lasted about one full day per site.

Since HHs are networks of providers, site visits to HHs were more complex, generally including a visit to the HH lead agency and visits to several participating agencies. The participating agencies that were visited included clinical sites, such as substance abuse treatment facilities and PC clinics, as well as case management agencies. Interviews were conducted with staff at each facility that we visited.

In general, clinic staff was eager to talk with the RAND research team; many clinics had prepared structured presentations and scheduled a full itinerary of interviews with administrators, providers, and consumers. Most of the interviews were conducted in a group format with a particular category of staff, e.g. psychiatrists, CM/CCs, or consumers. Administrators were not present during interviews with other staff members. Clinics were paid $1,100 for their participation. All site visit procedures were reviewed and approved by RAND's Human Subjects Protections Committee.

Site Visit Content Areas

During site visits, we addressed a wide range of topics, including clinic structures and the range of services provided; composition of the care team; the target population for integrated care; clinical processes and work flow; HIT and use of data for practice management and CQI; clinic culture of integration; and sustainability of integrated care services. Consumer perspectives on the clinic's approach to integrated care, including its perceived advantages and disadvantages, were also discussed. Within each of these content areas, we also discussed with informants how federal, state, and local policies were shaping integrated care, where clinics had created innovations to overcome challenges, and where significant challenges to integrated care remained.

Results

In what follows, we provide a comparison of three clinic types: PBHCI clinics, MI clinics (free-standing BH clinics), and clinics that are part of HH lead agencies. To do this, we first describe the structures, clinical processes, and challenges specific to clinics participating in each of the three integrated initiatives investigated in this report, calling out the policies that impact

them and the innovations developed by clinics to overcome barriers as they occurred. Thereafter, we describe issues and cross-cutting concerns reported by participating MH clinics of all types.

PBHCI Clinics

Structures

RAND visited three NYS PBHCI clinics, all of which were located in New York City. These sites share three important features in common. First, all three are located in densely populated areas where they serve a large number of adults with SMI who have complex medical needs. Two of the three PBHCI clinics served more than twice the number of adults with SMI than the largest of the non-PBHCI clinics included in the study. From the programs' perspective, having an economy of scale is an advantage when adding any specialized service that requires initial investments, such as improvements to clinic spaces, purchases of equipment, and hiring of staff, in addition to the ongoing expenses, which are mostly costs of paying staff for their time. Having a large number of patients who are likely to need PC services allows these programs to make the initial investments with some confidence that the services will be financially sustainable through reimbursements.

Second, all three of the clinics are located within large and sophisticated care delivery systems, either a health system that includes a large general hospital or a large and diversified human services agency that includes a wide variety of medical (e.g., FQHC), residential, and social programs. Two of the three clinics are within agencies that serve as leads for a health home. This is not surprising, since clinics or organizations with a prior interest in PC and the logistic and technical ability to write a grant proposal were more likely to submit successful proposals to SAMHSA for the PBHCI program. The large intra-agency network of providers puts these clinics in a relatively good position to find the appropriate clinicians, schedule PC services flexibly in response to demand, and support other resource and network intensive aspects of integrated care such as shared electronic health records, referrals to specialty care, and communication with emergency departments and hospitals. In addition, diversification within the parent organization allows these clinics to experiment with treatment models, such as provision of PC services, with reduced concern for their economic viability, at least in the short term.

Third, each of the PBHCI clinics we visited had actively engaged leadership with a longstanding interest in bringing PC services to their adult consumers with SMI. It is hard to overstate the influence that these leaders have on their organizations through their active pursuit of external resources and their thoughtful and creative problem solving within existing structures to maximize their impact. Actively engaged leaders have effects on provider culture and work processes throughout the clinic, both through the systems they establish for monitoring productivity and the example they provide through their own clinical work.

The PBHCI grants and the preexisting resources of the parent organizations allowed the PBHCI clinics to bring a wide range of resources to bear on the provision of PC services to

adults with SMI. As shown in Table 2.2, the services included extensive on-site PC services available full time or near full time exclusively for patients receiving mental health services. Two of the three clinics had DOH-licensed primary care clinics (Article 31 clinics) colocated with their MH clinic prior to their receipt of the PBHCI grant. This dual licensure, which is rare in NYS, means that these programs are able to provide PC services as comprehensive as found in a standard PC clinic. The third clinic had a nurse practitioner on site to see MH consumers four days per week, working in a standard PC examination room.

Table 2.2. Integrated Services at PBHCI Clinics and Their Parent Agencies

PBHCI Clinic	MH Services Within Clinic	Colocated PC Services	PC Services Within Agency or Health System	Care Management/ Coordination
1	Article 28 OMH clinic	Nurse practitioner 4 days/wk.	Health system with general hospital and multiple FQHCs.	9 HH CM/CCs
2	PROS, nursing/case management, Article 28 OMH clinic	Article 31 clinic at one MH clinic. Part-time PC screening, treatment services at others	FQHC-, school- and shelter-based programs	Health Home lead
3	Article 28 OMH clinic	HIV clinic, Article 31 PC clinic (with suboxone treatment), health care for the homeless, WIC, diabetes care, other subspecialty care	FQHC	Health Home lead

Clinical Processes

The PBHCI programs had well-defined clinical systems for providing PC services to their consumers. In two out of three clinics, a complete array of PC services was offered within the MH clinic or very nearby; PC services were offered during the majority of MH clinic hours. Available PC services included scheduled appointments, such as physical exams or monitoring of chronic physical conditions, and same-day visits on very short notice if a consumer was sick or came in with a medical concern. Since the PC was integrated into clinic work flows, clinic staff members were widely aware of the PC services and had an understanding of their role in consumers' PH care. Consumers confirmed the ease of access of the PC services and reported confidence that they could be seen for a PH concern at the MH clinic in a timely way.

An example of a fully integrated clinical process that we observed took place in one of the PBHCI clinics. During our visit, we attended a case conference led by the clinic director, a psychiatrist, who visits and provides services at the clinic about twice a week. The conference was held in a small staff room, attended by 15 staff, eight of whom had to stand due to limited space for chairs. In addition to the clinic director, the meeting included the clinic's CM/CC, a PC provider (an NP), the MH staff (Licensed Clinical Social Workers; LCSWs), and the program coordinator. The program coordinator had selected several cases for detailed analysis prior to the

meeting, identifying complex and problematic cases based on input from staff clinicians as well as analysis of data from the health system EHR and PSYKES. For instance, one of the cases discussed on the day we attended was a woman in her 40s with schizophrenia, polysubstance abuse and diabetes who had recently sought care from multiple emergency rooms for gynecological/obstetric care.

The clinic director led the case conference and was able to access the health system EHR throughout to explore both the medical and the psychiatric history. Information from the PC provider regarding the patient's diabetes management, from the case manager regarding her housing situation and family relationships, and from the MH provider regarding her MH status was reviewed and a treatment strategy developed. The direct involvement of the clinic director in this process not only improved the effectiveness of treatment planning, due to the director's clinical expertise, but also provided a model to all clinic staff of how to think through problems whose solutions required integrated care.

Remaining Challenges

During site visits, PBHCI clinics reported two major challenges in continuing to provide integrated services. First, communication between providers, including those within the same agency or health system and those in outside systems, remains a major challenge. Specifically, although providers reported that EHRs greatly improved information flow in some ways, they also added considerable complexity that sometimes limited their clinical utility. For example, all the PBHCI clinics used EHRs, and used them frequently, particularly for patients with complex medical needs. The presence of EHRs in PBHCI clinics was incentivized by SAMHSA, which offered an additional $200,000 to early PBHCI grantees to implement or enhance current health information technology (Scharf et al., 2014). At the same time, clinicians must access multiple systems to compile information on a single patient because hospital or health system EHRs are separate from case management EHRs and other agencies' EHRs. While the separateness of EHRs may be somewhat of an accident of history (different agencies purchased EHRs at different times to perform different functions), it also largely reflects the siloed activities and goals of the different agencies that must work together to provide consumers' integrated care. Barriers to integrated care also exist within an EHR, for example, because access to different types of information (MH and SUD information in particular) is frequently restricted to specialists and is not available to non-MD clinical staff. HH EHRs, on the other hand, were described as useful for CM/CCs who are tracking consumer attendance at appointments across specialties, but they were generally separate from medical records and not available to PC or MH staff.

Informants at PBHCI clinics (among others) indicated that fragmentation in information technology is partially due (as in other areas of health care delivery) to fragmentation of economic incentives. Specifically, EHR software providers have proprietary interest in their products and are paid on a fee for service (FFS) basis to provide ongoing technical support for

them. Policies that structure economic incentives to promote integrated care, such as accountable care organizations, may not effectively incentivize integration of health information systems. Policies that specifically incentivize integration of health information systems—not at the level of clinics or health systems, but at the level of EHR developers—may be required to make progress in this area. Indeed, PBHCI grantees were not held accountable for actually creating truly integrated EHRs, and only 10 percent of PBHCI grantees nationwide had integrated MH and PC records two years after the grant (Scharf et al., 2014). Grants (without accountability mechanisms) may not be the best mechanism to effect sustainable change, and other approaches to incentivization may be needed.

Second, although detailed economic analyses of the PBHCI approach to integrated care have not been conducted, clinic directors reported that the provision of PC services in MH settings is currently not financially sustainable without continued grant support. In general, administrators at the PBHCI clinics that we visited reported that they began to provide basic PC services, such as physical exams, to their adult consumers with SMI because they believed that it was the right thing to do for their consumers (independent of concerns about their financial impact). The PBHCI grant provided external funds to support expansion of these services, without demanding that the services be financially viable on a fee-for-service basis. However, in order to sustain these services over the long term, after the four-year grant period is completed, programs must find alternative ways to recover costs for the primary care services they provide, continue providing them at a financial loss, or simply stop providing them.

Among the sites we visited, two different strategies were proposed to make PC services sustainable in MH clinics. The first was to promote colocated PC clinics, licensed through the DOH, as two of the PBCHI clinics have already done. Those two clinics have had to go through two separate licensing application processes, one with OMH to be certified under Article 28 to provide MH care and one with DOH to be certified under Article 31 to provide PC services. In the past there has been discussion of a dual license process, which would offer a single license to provide both types of care, but to our knowledge, this license has been issued to only one clinic in the state. The second option is to allow MH clinics to be reimbursed for providing PC services. This is the option we discuss next.

Medicaid Incentive—Health Physicals/Health Monitoring

Structures

The OMH billing codes for health physicals and health monitoring (OMH's Medicaid Incentive, or MI initiative) were used in all three of the PBHCI sites as well as two other MH clinics that we visited. In contrast with the PBHCI sites, which were all in the NYC area and part of large medical or social services systems, the two additional sites providing health physicals and health monitoring were freestanding MH clinics in upstate, rural, or semi-rural areas. One of the clinics was county-run, while the other was part of a small human services agency. In this

section, we focus on those two clinics as examples of clinics for which the OMH billing codes for health physicals and/or health monitoring are the main or only source of support for PC services. As noted above, these sites were selected because their leadership had a longstanding interest in providing PC services to their adult SMI consumers and were not meant to be representative of freestanding MH clinics more generally. In fact, both clinics had made significant investments in PC services prior to gaining approval from OMH to bill for those services.

Both of the MI clinics we visited were licensed by OMH under Article 28 as MH clinics. Both provide a similar set of MH services, including social work, supportive psychotherapy, psychiatric evaluation, and medication management to consumer populations largely covered by Medicaid. The total consumer caseload was approximately 650 at one clinic and 900 at the other. Both clinics were colocated with PROS (Personalized Recovery-Oriented Services, i.e., psychiatric rehabilitation day treatment) programs, although in the case of the county clinic the PROS program was run by a separate private nonprofit agency. The fact that each of these clinics was colocated with a PROS program is notable because in some ways, the clinics were already accustomed to integrating psychiatric rehabilitation services (PROS) and psychiatric medical treatment provided on site. Most of the consumers who used the PROS clinics received their psychiatric care there and were familiar and comfortable with the clinic and its staff. Close ties with the PROS program allowed for some integration of clinic care with wellness services; for instance, clinic providers referred consumers to smoking cessation or weight loss services at the PROS program. On one of our site visits, our tour of the clinic was provided by one of the consumers attending the associated PROS program.

In both clinics, administrators, CM/CCs, clinicians, and consumers themselves stressed the difficulties faced by adults with SMI in accessing PC services in the community. Informants of all types reported that the most basic problem limiting PC access was the lack of providers in the community who accept Medicaid. Administrators at each clinic could quickly name the short list of local providers who did accept Medicaid and who also cared for their consumers. Moreover, in both clinics CM/CCs reported that their consumers have been barred from using local PC clinics because of multiple missed appointments, and as a result, many consumers relied on local emergency rooms for routine PC. To address these needs in the populations they serve, both clinics had already made efforts to provide or coordinate PC services prior to receiving approval to bill for health physicals and health monitoring For instance, both of the clinics had prepared rooms to provide physical exams in the hope of finding primary care providers.

Clinical Processes

In contrast with the PBHCI clinics, PC services in the two clinics using the MIs did not reflect a clinicwide orientation toward integrated care. Specifically, health physicals were provided to consumers during the MH clinic intake process, which satisfied a regulatory requirement, and monitoring of health status was largely focused on potential side effects of

third-generation antipsychotic medications. The services were provided by clinic nursing staff, who did not work closely with the clinic MH providers or CM/CCs. Most staff, including the PC providers themselves, was not aware that the clinic had received special permission to bill for health physicals or health monitoring; only the administrative staff directly involved in billing were aware of the program. Both of the MI clinics we visited actually had PC examination rooms that were built to house PC providers but remained unused. In short, the PC services available (i.e., those limited services allowed under the expanded license) are provided as adjunct services rather than integrated into a comprehensive approach to patient care, despite the efforts of clinic leadership to move their organizations in this direction.

Both clinics had recently introduced electronic health records, and access to these systems remains limited to clinic or agency staff. Integration of information from other providers remains on an ad hoc basis. For instance, even if a patient has consented to allow sharing of medical information, records from a hospitalization must be requested from the hospital by clinic staff and scanned into the local EMR; MH and hospital EHRs do not interface automatically. The same was true for records of PC physician visits. The clinic's ability to get information often depends on personal relationships between providers; they reported that they were much more likely to receive records from a psychiatric hospitalization than from a hospitalization for a physical health condition. Interest in integration from the PC side appeared to be minimal. One experienced clinician noted: "I have never had a primary care doctor call me about one of our patients."

Remaining Challenges

Even with the ability to bill Medicaid, it was unclear if health monitoring and health physicals were financially sustainable through reimbursement alone. In fact, administrators at both clinics reported that the reimbursement from Medicaid for health monitoring or health physicals did not cover the cost of providing the care, even after they had made the initial up-front investments in facilities and staff to provide it.

Moreover, the types and amount of PC services provided at these clinics remains limited; neither clinic employed an MD for PC services. Given the limited capacity for medical care, any indications for follow-up testing or treatment must be referred back to the outside providers, who were difficult to access. To fill this need, administrators in both of the clinics actively sought community providers who would see consumers on site. The director of one of the programs reported making several unsuccessful attempts to have a local health system set up an Article 28 (full-service PC) clinic in their building, saying "I would do it in a minute." Forthcoming increases in Medicaid reimbursement to Medicare levels (e.g., Kaiser Family Foundation, 2012a, b) may improve physicians' willingness to participate in integrated care for adults with SMI and help get such partnerships up and running. In any case, the potential local partners did ultimately decide not to go forward with these plans. Following those unsuccessful efforts to bring in an external PC provider, the director applied to DOH for a new Article 28 license, but that

application has been under review for over a year. Regional provider shortages play a large role as well; clinic staff described having few local options for PC referrals for Medicaid-insured consumers. These limitations of the health care network are addressed in the next integrated care initiative operating in NYS to be discussed, Health Homes.

Health Homes

Structures

As described in the introduction, health homes (HHs) have been rolled out statewide as supplemental care coordination systems focused on high users of medical services with complex medical needs. The goal is to improve quality of care and reduce the cost of unnecessary care by improving coordination across multiple providers. MH clinics may be involved in health homes in a variety of ways. First, they may be part of an agency that serves as a lead agency for an HH. The lead agency serves as an information clearinghouse for the HH, maintaining lists of enrollees and affiliated providers and administering payments for case management activities. Second, MH clinics and the agencies that run them often house or are affiliated with the individual CM/CCs who fulfill the case coordination role for the HH. CM/CCs may work in the same building as an MH clinic and have more direct contact with MH providers than with other community providers. Third, MH clinics are likely to be involved in HHs simply because they treat adults with SMI, one of the populations targeted for HH enrollment.

Clinical Processes

CM/CCs are at the core of the HH model for integrating care. Although this particular model of case management is new, case management has been used in a variety of settings for many years, including care for adults with SMI, SUDs, and HIV. In fact, the majority of the CM/CCs we met with during site visits had prior experience in one of these positions. In some cases agencies that had provided a particular type of case management were transitioned entirely into the HH model. This past experience is a great benefit to the HH because CM/CCs bring with them extensive knowledge of local health care providers and social service agencies. While some adjustment was needed to the new role within the HH—e.g., CM/CCs with prior experience in MH had to learn about consumers' PH conditions and the primary health care system—the CMs found the work familiar in most respects and brought knowledge and skills to the task.

Enrollment and Consent

At the time of this research, NYS' HHs were still in the early stages of implementation, and a major task of CM/CCs was enrolling clients in the HH. Individuals became eligible for enrollment in two ways, as either "top-down" or "bottom-up" referrals. Top-down referrals were those individuals who are identified by the state on the basis of their past health care utilization as eligible. Lists of names and addresses were provided to the HH lead agency and then passed down to CM/CCs who are tasked with making contact with the listed individuals and engaging

them as HH enrollees. Informants consistently reported that locating the top-down referrals was a very difficult task; the consensus among CM/CCs we spoke with was that they were able to contact about 20 percent of the top-down referrals. In contrast, bottom-up referrals were individuals identified by CM/CCs as candidates for HH enrollment based on their clinical diagnoses and treatment history. Bottom-up referrals were eligible for enrollment after being recommended by the HH lead agency and approved by the state. Since the bottom-up referrals are known to the CM/CCs at the time of referral, much less work is required to complete their enrollment in the HH. Indeed, one clinic we visited described nearly abandoning the top-down referral process and instead using connections with the local community (through social services and community events) to publicize the HH and work through social networks to identify and enroll potential HH beneficiaries.

Enrollment in an HH entitles a client to case management services, but the full benefit of integrated care depends on sharing of protected health information among providers within the HH. Before protected health information can be shared, clients must provide their consent. Surprisingly, we found wide variation across groups of CM/CCs in success obtaining consent from enrollees. Some groups of CM/CCs appeared to have no difficulty obtaining consent; they reported that enrollees had minimal concerns about sharing information and that signing the consent forms rarely raised a concern. Other groups, particularly those working with high proportions of clients with SUDs and/or HIV, reported that obtaining consent was a major hurdle; their clients were very concerned about privacy and a large portion simply refused to consent. We do not have an estimate of the proportion of enrollees who have not provided consent, but, if the proportion refusing consent for information sharing is high, then the HH may be constrained in its ability to integrate care efficiently. While we did not learn of any specific strategies to obtain consent, we observed that consumers were more likely to give consent to CM/CCs with whom they were familiar already, particularly if those individuals were members of their communities (e.g., ethnic, cultural communities). For example, at one clinic serving a high proportion of Hispanic and Latino clientele, clinic staff reported that a Hispanic CM/CC was able to enroll more than 85 percent of consumers in the HH and obtain consent for information sharing at the time of enrollment.

Case Management

Once individuals are enrolled in an HH, CM/CCs provide a wide range of ongoing support to ensure that the individuals' health needs are met. CM/CCs tend to be pragmatic problem solvers, working with each enrollee to identify health needs, find providers who can address those needs, and ensure communication between providers to integrate their treatment plans. Depending on the individual, CM/CCs may accompany him or her on visits to doctors or help with finding housing or navigating social service bureaucracies. Some enrollees with complex problems and impairments may require frequent intensive services, while other, more self-sufficient enrollees require much less attention. For all enrollees, CM/CCs are the key to the success of the HH,

ensuring adherence to treatment on the part of enrollees and better integration of care across providers. To fulfill this role, CM/CCs must have detailed knowledge of the clinic needs and functional abilities of the consumers in their caseload.

Integration of medical records is one way to facilitate the sharing of information needed to make HHs successful. If enrollees consent to have their information shared across providers, their care can be integrated more effectively. However, one of the primary concerns we heard from CM/CCs at each of the sites we visited is that the systems for sharing health records were not sufficiently integrated to fulfill this function. Different providers used different EHR systems, across which information sharing was often not possible. Access to various systems followed complex rules, so that CM/CCs may have access to some but not all the EHRs in which medical information on their consumers is stored. In addition, the introduction of an EHR specifically for the CM/CCs to share records of the HH enrollees added an additional health information system that did not interface with other systems, perhaps increasing rather than decreasing the fragmentation of information. The HH EHRs also raised concerns among the MH clinic staff because they added complexity to existing systems, in particular for clinics serving consumers enrolled in more than one HH. Since each HH had a separate EHR, clinic staff had to learn multiple systems and track which consumer belonged to which HH.

A notable innovation at one of the sites we visited was that the clinic had created a specific care coordinator (CC) position to work interactively with the case management team. Specifically, the CC was a medical nurse who worked in an office setting, scouring all of the available information systems in order to identify consumers in the HH who were not in regular contact with the system or who were demonstrating concerning patterns of engagement with care (e.g., hospitalizations, emergency visits). This staff person then reached out to the assigned CM, who then prioritized contact and follow-up with the identified consumer. Informants at this clinic reported liking the system because it dedicated computer and medical tasks to an individual with computer and medical expertise, and allowed individuals who preferred fieldwork to be active in the community and not tied to a desk. At this same site, the clinic appeared to wholeheartedly adopt the HH model, widely describing the CM as the head of the care team—essentially making this individual responsible for identifying consumer needs across domains and, with support from the CC, connecting consumers to the appropriate mix of services. This site also depended heavily on a "virtual colocation of providers," a web-based system that allowed providers across locations to communicate about consumer needs in real time. This platform has a dashboard to highlight the most pertinent consumer information, and individual users can subscribe to real-time alerts regarding particular changes in consumer status. CMs at this location used the platform as a clinical registry, generating lists of consumers with specific identified needs. In addition to consolidating multiple streams of information from providers on the care team, the virtual colocated system was also integrated with the RHIO. A challenge of this approach was that providers with only a few consumers enrolled in the HH were unlikely to use the system since it required them to go outside of their local EHR.

Remaining Challenges

The major concern among CM/CCs across site visits was that the caseloads they were expected to carry were too large and not sustainable under the proposed reimbursement structure. The caseloads that CMs were expected to carry were, in some cases, three to four times as large as the caseloads they carried in their previous positions. According to CM/CCs, the expectation was that the intensity of the case management will, on average, be significantly lower in the HH setting than, for example, in the state's prior intensive case managements programs. However, given that HHs were still in the early stages of implementation and operation, CM/CCs did not yet have a good sense of how much time would be required and were apprehensive about the size of their caseloads. Moreover, they were spending much of their time identifying, locating, and enrolling people into the health home rather than providing case management. CMs did not yet have a good sense of how much work would be involved in providing HH case management services when they reach a point where their caseloads are stable.

Reimbursement for CM/CC services is paid to the case management provider agencies on a PMPM basis. The PMPM varies by severity: There is a fivefold difference in the PMPM between the lowest and the highest severity ratings. However, the PMPM does not vary by the amount of service provided to the consumer during the month. Since the CM/CCs had yet to settle into stable work patterns, it is not yet known whether the reimbursement schedule will be sustainable for these agencies, but there is enormous concern among the CM/CCs that reimbursements will not adequately cover their costs. In addition, informants reported concern that the classification system used to determine severity does not accurately reflect the amount of case management services that a consumer needs. Finally, there was also concern that the cost to provide CM/CC services is substantially higher in rural areas, where CMs must travel longer distances, and that the PMPM rates do not sufficiently account for these differences.

HH CM/CCs were also concerned about their ability to effectively network with community providers. One of the most common concerns we heard, in both rural and urban HHs, was that community providers of all types were completely unaware of HHs and did not understand how they are supposed to work. When CM/CCs contacted providers, they reported encountering misunderstandings—providers often confused them with home health workers—and mistrust—providers often did not accept the HH consent form, requiring a new consent procedure before sharing protected health information. While misconceptions about the HH may change over time, at the time of this research, lack of understanding and awareness of the HH model among community providers remained a major point of frustration for CM/CCs.

Shared Concerns and Cross-Cutting Issues

Challenges to integrated care that were shared across clinic types included urban/rural differences, licensing, patient perspectives on integration, and use of HIT. We discuss each of these issues in turn,.

Urban/Rural Differences

Compared with BH clinics in urban areas, there are some additional barriers to integrated care that MH clinics in rural areas face. Most importantly, the shortage of PC providers in rural areas is a fundamental barrier, which makes the need for PC among the SMI particularly acute and difficult to address. Where PC providers are in shorter supply, MH clinics are likely to have difficulty providing PC services, even if the reimbursement barriers are removed. Further, MH clinics outside of urban centers were more likely to be freestanding rather than part of large, diverse health systems or provider agencies. Consequently, they were much less likely to have sophisticated electronic medical record systems to facilitate integration of care. Finally, distances that must be traveled in rural areas are much longer, requiring more time from CM/CCs and imposing further costs.

Licensing

The clinics we visited were primarily licensed by the OMH to provide a scope of services that excludes even basic PC services. However, even with the MI health monitoring and health physicals program, clinics expanded their scope of practice to include only a limited number of PC procedures. As such, clinic staff was still challenged to find reliable treatment services for their consumers' PH conditions, and consumers were unlikely to feel engaged in the clinic's PH services because they could not address their emergent PH needs. To solve these problems, MH clinics were interested in creating colocated PC clinics that are licensed by the DOH, but very few of them were able to do so successfully. In addition to difficulty finding interested PC partners and/or ability to invest in PC infrastructure to make hiring of independent PC staff to provide PH services possible, the time and investment to satisfy dual licensing requirements was prohibitive for many clinics (some of which report that their license applications were under review by the state for more than a year). In our experience, freestanding MH clinics (without shared administration and/or infrastructure with PC agencies) were at a particular disadvantage in pursuing licensing strategies to allow them to implement PC on site.

The need for harmonization across the licensing requirements from the three main licensing authorities in the state, the DOH, OMH, and OASAS, was brought up in several site visits. For instance, one MH clinic was located right next door to a PC clinic (very close to a pharmacy and social service agency, as well). Clinic administrators were eager to take advantage of this proximity by coordinating appointment scheduling for their consumers. However, licensing required that the scheduling staff and the waiting areas for the two clinics be kept separate. Case managers, therapists, or other clinic staff had to help consumers coordinate their appointments; work that would not have been necessary if it were possible to make those appointments centrally. The requirement that the clinics be physically separate meant that consumers could not flow easily between the two spaces. In a different but related case, an OASAS had built a PC clinic on a higher floor within the same building. However, the regulations required that the PC clinic have a completely separate entrance. Rather than simply walk up a flight of stairs from the

OASAS clinic to the PC clinic, consumers had to leave the building and enter through a second, newly constructed entranceway.

Consumer Perspectives

At most of the site visits we were able to talk with consumers, either in groups or in one-on-one interviews, about their experiences with PC in general and the possibility of receiving PC services in the MH clinic. Clinic staff arranged the meetings. In some cases we sat in on group meetings that were already scheduled, in others we met with consumers who happened to be in the clinic on the day of the visit, and in others the clinic staff had recruited participants and asked them to come to the clinic specifically to talk with us. Most of the conversations were face-to-face, but several were conducted over the phone. Discussions with clinic staff suggest that the sample of consumers was not representative of the adult SMI population or the clinic populations. In particular, it is likely that they were more severely ill and had stronger ties to the clinic we were visiting than most consumers. We note this because these factors may be related to consumers' attitudes towards receiving PC services at the same clinic where they receive MH care.

Consumers voiced many of the same difficulties with PC services noted by administrators and clinicians. In the more rural clinics, consumers were very aware of the shortage of PC physicians who accept Medicaid. As observed in other studies (Scharf et al., 2014), transportation was a major issue for consumers in both rural and urban areas. Consumers had to travel long distances by public transportation, often because they had a limited choice of where to get care. For many, due to limited public transportation options, going to see a doctor could take nearly a whole day considering the waits required for buses and in busy doctor's offices. Medicaid will cover cab rides for some medical visits, i.e., in "Medicaid cabs," but consumers were hesitant to use them; the cabs can be unreliable, and some consumers reported that they do not want to appear to be taking advantage of a public service.

Consumers also voiced serious complaints about the treatment they received at community (i.e., non-MH-based) PC clinics. We frequently heard reports that PC clinics did not want to have them as patients and that PC clinicians did not understand mental illness, did not want to treat patients with mental illness, or did not want to hear anything about their mental illness, even when they were treating them for another condition. One consumer told us about a physician's assistant in a PC clinic who "did not want to touch me." As a consequence of the stigma associated with mental illness, consumers reported feeling that they did not receive quality care in primary health care clinics (which is consistent with empirical research; Druss et al., 2010). Clinicians would prefer, consumers said, to refer them to care in emergency rooms than provide them care directly.

Not surprisingly, when we asked consumers whether they would prefer to receive their PC services in the same clinic where they receive their MH care, we generally heard enthusiastic responses. In addition to the convenience of getting physical and MH care in the same location

and setting, where many already attend a day program several days a week, consumers were confident that they would receive better, more respectful, and more integrated care.

At the same time, there were exceptions to this pattern that raise some important questions for future research. We conducted several interviews with consumers who tended to be more independent despite having SMI as well as serious chronic physical health conditions. These informants reported recognizing the potential benefit of clinics making PC services available in the MH clinic, but they did not see it as a priority or an advantage for them personally. For instance, one woman with bipolar disorder who received psychiatric care at a clinic we visited also suffered from a kidney condition for which she received regular dialysis treatment. She lived independently with her family, and had been seen for a long time by a local PC physician. She had no interest in receiving PC services at the MH clinic where she received psychiatric care, preferring to receive care for her PH conditions at one clinic, her dialysis at a dialysis center, and care for her MH condition at a third location.

The few consumers who were satisfied with their current PC services not provided in an MH setting suggest that this arrangement is not for everyone. Furthermore, there may be good reasons individuals with SMI prefer one or the other setting for their PC. Gaining a better understanding of the factors that influence these preferences is important, because the target population may need to reduce the burden on the small number of providers willing and able to serve the population while also creating sufficient clinic census to make services sustainable. For instance, we visited one clinic that was establishing a new, colocated Article 28 PC clinic whose innovative sustainability plan was to prioritize appointments for consumers in the MH clinic but to also treat others in the local HH, plus consumers' family members and caregivers who were often also part of various underserved communities (e.g., poor, immigrant). In general, our conclusion, based on the interviews and focus groups we have conducted to date, is that consumers who are more integrated with their MH clinic, for whom the clinic and the associated day program play an important role in their social networks and daily activities, will be more likely to prefer to also receive their PC services at the MH clinic. For this group of consumers, this arrangement of services would be a very welcome change in the delivery system. However, other consumers with SMI do not rely on psychiatric services to provide important social integration and community in their lives, such as those who are more independent and possibly employed. For this group, including those with serious chronic PH conditions who require specialty PH care, moving PC treatment into an MH setting may not be an improvement. In fact, for these patients, integration of psychiatric care into primary care may be a preferred option. This hypothesis is consistent with Mauer's (2006) model for the locus of consumer care (Figure 1.1), and additional research focusing on the appropriateness of different integration strategies for different types of consumers is needed.

Use of System-Level Health Information Technology

Virtually all of the clinics we visited are aware of the electronic health information systems available in NYS, in particular the RHIO and the PSYKES, but there was wide variation in the extent to which these resources were used. The RHIOs comprise groups of providers who share a service area and agree to share health information on their patients in the interest of integrating care. PSYKES is a quality improvement system run by the OMH that provides patient-level utilization information to clinics based on Medicaid billing claims. In the clinics that are most aggressive in integrating care, these systems are routinely accessed for information on specific individuals and to identify individuals who are using large amounts of care or inappropriate care (e.g., multiple ED visits and/or hospitalizations). In the more rural, freestanding clinics administrators are aware of the resources, but use of them was in its early stages.

Summary and Discussion

The site visits allowed us to observe and compare three approaches to integrating primary care services into behavioral health clinics, each under ideal circumstances where these efforts have active support from clinic leadership. The PBHCI and Medicaid Incentive programs represent two strategies, varying in intensity, that both have the goal of bringing PC services into MH clinics. The PBHCI program aims for a clinicwide transformation of clinical processes, and it provides dedicated short-term funding, not tied to reimbursement, for achieving that goal. In contrast, the Medicaid Incentive program simply allows for reimbursement for a much more limited set of PC services and does not support or require clinic restructuring. The contrast between the PBHCI and the MI clinics suggests that integrating care requires more than an incremental addition of services to the existing offerings in MH clinics.

The health home model is an entirely different approach, which nonetheless has the potential for major impacts on MH-centered PC services. While the hope is that the health homes will provide the needed integration of care across providers for many of the adult SMI consumers served by freestanding MH clinics, it is still too early in the process of health home development to assess whether they will be effective in this regard. If HHs are successful, they may fulfill the role of integrating PC and MH services for the SMI population, obviating the need for MH clinics to restructure their clinical processes.

Finally, it is also important to note that the contrast between the PBHCI and MI clinics in this report is affected by the fact that the PBHCI clinics are all located in NYC and the MI clinics are located in rural or semi-rural areas of the state. All of the clinics in the state that received PBHCI grants from SAMHSA are located in the New York City area, so we were limited in our ability to select a more regionally diverse sample. However, as described above, regional variations in health care networks have important implications for integrated care. Integrated care is facilitated in urban areas such as New York City by dense networks of diverse health care providers and the large population from which patients can be drawn. However, even in urban areas, many

practical barriers to networking across sectors of the health system remain. In more rural areas, provider shortages, which particularly limit options for Medicaid enrollees, impose an additional structural constraint on integrating care, even though the need may be greater.

Chapter Three. Surveys

In this chapter, we describe the experience of NYS's MH clinics providing integrated care to adults with SMI with data from two separate but complementary surveys: (1) a clinic-level survey, completed cooperatively by one or more clinic administrative staff, describing the characteristics of the clinic's integrated MH and PC services; (2) a provider-level survey, completed by individual PC, MH, and CM/CC providers, detailing their experiences delivering integrated care in relation to the MH clinic. Respondents to the provider-level survey were selected from within the clinics that participated in the clinic-level survey.

Both surveys covered similar topics, including clinic structure, range of services provided, composition of the care team, target population and consumer served, clinical work flow, HIT and use of data for practice management and CQI, clinic culture of integration, and sustainability. Following a description of the survey methods, we present the results of the surveys together, as they each help us answer the three research questions guiding this report.

A major limitation of our survey research is that response rates to the clinic and provider surveys were low, limiting our capacity to test for differences between the three integrated care initiatives examined in this report. As such, integrated care initiative group "differences" are merely descriptive and perhaps suggestive of directions for future research.

Methods

Clinic Administrator Survey

Survey Format

The clinic-level survey was issued as a fillable, savable PDF document (if received electronically) or on paper. Respondents were instructed that more than one person could complete the survey if necessary, since no one person may have had ready access to all of the relevant information. A copy of the clinic survey is in Appendix D.

Sampling

Our original target sample for the survey was 58 adult MH health clinics throughout the state. The target sample included all eight NYS PBHCI clinics, plus an additional 50 clinics randomly selected from a list of OMH-licensed general or adult (i.e., not pediatric) clinics. The list of clinics was stratified by region (i.e., Central New York, Hudson, Long Island, New York City, or Western New York) and by clinic MI license status (license to provide health monitoring, health physicals, or both vs. no MI license). All clinics were participating in HHs, either as a lead

agency or as a network provider. In total, we sampled ten clinics from each of the five regions of the state; 25 of these 50 clinics were MI clinics.

Recruitment

We sent email invitations to the 32 clinic directors whose contact information was available online. Five email reminders were sent to potential respondents, followed by at least two additional reminders by phone. The remaining 26 clinics for which we could not identify an email address were sent paper surveys through the mail. Paper survey recipients also received at least two reminders by phone to complete the survey.

The original survey period was from February 8 to March 31, 2014. However, due to a low response rate (n=11 of 58 clinics, or 19 percent), we randomly sampled an additional 50 OMH-licensed clinics in April 2014. The second sample was created using the same stratification criteria detailed above; note that no additional PBHCI clinics were added because all New York grantees were contacted during the first sampling wave. During the second wave of sampling, an additional 42 clinics received the PDF survey through email, and the remaining eight clinics received paper surveys through the mail. Follow-up procedures for the second wave of sampling were the same as during the first wave.

Finally, from April 21 to May 4, 2014, we made a last attempt to increase survey responses and identify reasons for survey nonresponse. To do this, we sent a one-question survey to clinic directors who had not responded to the survey thus far. The one-question survey was sent through a unique link to clinic directors' emails (n=73) or through the mail (n=8). Twenty-five (31 percent) of the 81 previous nonresponder clinic administrators indicated that they had not previously participated in the survey due to: its length (n=4, 16 percent), the fact the clinic was not offering any integrated care (n=4, 16 percent), not having seen the original survey in their email (n=2, 8 percent) or other reasons (n=4, 16 percent). Upon receipt of this email however, n=11 (44 percent) indicated that they changed their minds and wanted to participate (resulting in our receipt of an additional five surveys).

The data collection window was closed on May 9, 2014. The final clinic-level survey sample included completed surveys from n=22 unique mental health clinics (20 percent response rate). Additional detail about the clinic sample is reported in the results.

Provider Survey

Survey Format

The provider survey was a web-based survey, hosted on the SurveyMonkey software platform (https://www.surveymonkey.com). SurveyMonkey is a simple yet customizable platform that allows users to design text-based surveys (including standard graphic features such as radio buttons and drop-down menus, and back-end features such as skip-patterns) for simple, reliable, and efficient data collection. A copy of the provider survey is in Appendix E.

Sampling

Provider survey respondents were selected from within the clinics that participated in the clinic-level survey. Clinics that responded to the program-level survey were asked to submit lists of two PC, MH, and CM/CC providers, respectively, including email addresses, to participate. Once these lists of names and email addresses were received, we sent a unique link to individual providers to complete the web survey; this allowed us to maintain a link between data provided by providers and the administrators at their respective clinics.

Recruitment

All providers nominated by administrative respondents received up to five email reminders to complete the survey, and of the 49 total providers contacted, n=34 responded. This resulted in a total provider survey response rate of 69 percent.

Respondents were PC providers, MH providers, and CM/CCs. Primary care (PC) providers (n=3) were physicians (n=2, 67 percent) or a physician assistant (n=1, 33 percent). Mental health (MH) providers (n=26) were psychiatrists (n=2, 8 percent), psychiatric nurse practitioners (n=2, 8 percent), a psychologist (n=1, 4 percent), or various kinds of therapists (n=19, 76 percent). MH respondents additionally identified as a supervisor (n=1; 4 percent) or licensed clinical social worker (n=1; 4 percent). CM/CCs were case managers (n=4, 80 percent) or a social work assistant (n=1, 20 percent); CCs also identified as peer-care manager/health coach (n=1, 20 percent), or supervisor (n=1, 20 percent).

Program and provider respondents answered questions about their agency's main mental health clinic.

Definitions of Key Constructs

Definitions of key constructs were the same for the clinic and provider surveys.

Adult consumer with SMI. Adults 18 years or older who receive MH services and have a diagnosis of schizophrenia, other psychotic disorder, bipolar disorder, or major depression.

Care Management and Coordination (CMs/CCs). Staff who provide individualized support to help consumers navigate health and/or social service resources. Staff providing these services may be referred to as case managers, care managers, or care coordinators.

Clinical registry. A collection of clinical information (e.g., diagnoses, individual service use encounters) that can be used to track, monitor, deliver, and improve core services for a specific group of consumers.

Main clinic. The main clinic was defined as the main site licensed by the OMH to provide outpatient MH care; although agencies may have satellite locations under the same license, respondents were directed to answer questions only with respect to the main clinic.

Physical health services. Medical and preventive services provided for MH consumers that are not traditionally provided in MH settings—for example: physical exams, exercise classes, monitoring of chronic physical illnesses (e.g., diabetes), or treatment of an acute medical

condition such as an ear infection or sore throat. These services may be provided on site at the MH clinic, coordinated by a case manager or care coordinator, or provided by a partner agency through a formal memorandum of understanding or contract.

Sensitivity Analyses

PBHCI clinic administrators were more likely to respond to the survey than administrators at other clinic types (PBHCI response rate 63 percent vs. MI clinic response, 20 percent, and non-MI clinic, 14 percent), possibly because they knew RAND researchers from prior evaluation work and/or because they were accustomed to similar evaluation requests from other groups. Similarly, respondents were more likely to be from New York City (36 percent response rate) than other regions of the state (Central, 10 percent; Hudson 0 percent; Long Island 25 percent; Western, 25 percent). Additional detail about the distribution of program survey respondents is in Appendix B.

Among eligible providers, MH providers (87 percent) responded at higher rates than PC (60 percent) or CM/CC (42 percent) providers.

Results

In this section, we present clinic administrator and provider survey data as they pertain to each of the three project research questions: (1) shared and distinctive clinic features; (2) policies and strategies impacting care delivery and sustainability of integrated care; (3) innovations in integrated care implementation, operation, and sustainability.

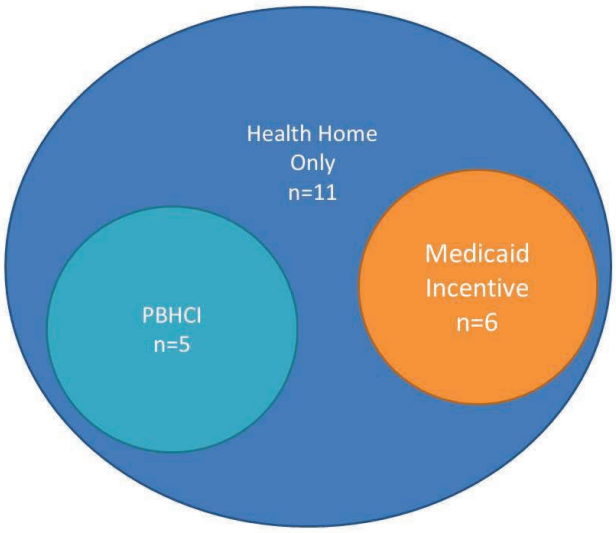
Research Question 1: Shared and Distinctive Features

The shared and distinctive features of clinics participating in NYS's integrated care initiatives are described below, including descriptive information about respondents' main clinic structure, range of services provided, composition of the care team, target population and consumers served, clinical work flow, HIT, use of data for practice management and CQI, and clinic culture of integration, and how these structures varied across the integrated care initiatives under study.

Participation in Integrated Care Initiatives

Clinic administrators described their main clinic's participation in each of the three integrated care initiatives examined in this report (Figure 3.1). All respondent clinics had affiliations with HHs (n=22, 100 percent), acting as lead (n=6, 27 percent) or more commonly as member agencies (n=16, 73 percent) in more than one (M=1.7, SD=1.1) HH. Six clinics reported holding MI licenses for health monitoring and/or health physicals, although only five (83 percent) reported that they were using the MI-specific billing codes to support PC services. Nearly a quarter (n=5; 23 percent) of survey respondents had received a SAMHSA PBHCI grant.

Figure 3.1. Clinic Participation in Integrated Care Initiatives



Licensing

A key factor affecting the type and scope of services provided by clinics is the state operating license held by those clinics (Table 3.1). In New York state, PC services are regulated by the DOH, while MH services are regulated by the OMH. SUD services are regulated by a third agency, OASAS. Clinics intending to offer more than one type of service must obtain additional licenses from the appropriate regulatory agency to support an expanded scope of care.

According to administrators, main clinics were largely covered under OMH Article 31 mental health clinic licenses (86 percent)[1]. MH clinics offered PC services under DOH Article 28 licenses (23 percent), and less commonly under MI licenses for health physicals (14 percent), or health monitoring (27 percent). Few clinics had received dual (OMH-DOH, 9 percent) or co-license (5 percent) options for integrated care.

Licenses held by respondent main clinics varied by clinic type. Specifically, PBHCI clinics held a variety of licenses, including DOH Article 28 (full-service PC licenses), and other specialty licenses including dual and co-license options; no PBHCI clinics held MI licenses. MI clinics also held a variety of licenses, including health monitoring and health physicals licenses, plus OASAS licenses (for SUD services) and occasionally other PH licenses, as well. Only one HH clinic held any kind of additional or expanded (dual or co-) license for PH services (DOH Article 28)[2].

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[1] All respondent clinics held OMH licenses (all were sampled from an OMH list); however, some may have held licenses other than the Article 31 license.

[2] By definition, if these clinics had held expanded health physicals or health monitoring licenses, they would have been classified as MI clinics for this research.

Table 3.1. NYS Licenses Held by Main Clinics, by Clinic Type

License	License held, total (n, %) N=22	Clinic Type		
		PBHCI n=5	MI n=6	HH only n=11
Office of Mental Health (OMH)				
Article 31	19 (86)	4 (80)	5 (83)	10 (91)
Expanded license for health physicals	3 (14)	0	3 (50)	0
Expanded license for health monitoring	6 (27)	0	6 (100)	0
Comprehensive Personalized Recovery Oriented (PROS)	0 (0)	0	0	0
Limited Personalized Recovery Oriented (PROS)	0 (0)	0	0	0
Office of Alcoholism and Substance Abuse Services (OASAS)	4 (18)	1 (20)	3 (50)	0
Department of Health (DOH) (Article 28)	5 (23)	3 (60)	1 (17)	1 (9)
OMH-DOH special dual license	2 (9)	1 (20)	1 (17)	0
OMH-DOH co-license option	1 (5)	1 (20)	0	0
Other	2 (9)	0	2 (33)	0

NOTE: The other two license types are an integrated license and a separate agency program for CD; totals can exceed 100 percent since respondents could “check all that apply.”

Clinic Structures and Services

Participating clinics were diverse, representing urban (55 percent), suburban (32 percent), and rural (14 percent) regions of the state (Table 3.2). Clinics also varied in size, both in terms of total consumers served (ranging from 112 to 90,000) and in their adult populations with SMI (50 to 12,670). One third (36 percent) of clinics were part of health systems that included a general medical hospital. Clinics also varied in terms of experience offering integrated care, with programs ranging in age from 1 to 20 years.

Clinics participating in each integrated care initiative varied in structure and services provided. In NYS, PBHCI clinics were exclusively in urban settings, while other clinic types were also in suburban and rural areas. In general, PBHCI clinics were more than ten times larger than either MI or HH clinics (by total census), serving five times more adults with SMI than participating MI or HH clinics. PBHCI clinics were twice as likely as other clinic types to be hospital affiliated, although no more experienced at offering integrated care than HH clinics. MI clinics tended to have less experience offering primary care services.

Table 3.2. Clinic Characteristics, by Clinic Type

	Overall N=22	Clinic Type		
		PBHCI N=5	MI N=6	HH N=11
Location (n, %)				
Urban	12 (55)	5 (100)	3 (50)	4 (36)
Suburban	7 (32)	0 (0)	2 (33)	5 (45)
Rural	3 (14)	0 (0)	1 (17)	2 (18)
Clinic size (M, SD)				
Total consumers	5206 (19424)	18820 (39793)	1615 (1746)	978 (787)
Total adult SMI consumers	1111 (2629)	3153 (5359)	629 (532)	447 (421)
Hospital affiliation (n, %)	8 (36)	3 (60)	2 (33)	3 (27)
Years offering integrated care (M, SD)	6 (7)	8 (8)	4 (5)	8 (10)

MH clinics offered a variety of PC services to their adult consumers with SMI, typically through partnerships with other organizations (n=18; 82 percent); that is, organizations with whom the MH clinic agency had a formal memorandum of understanding or contract. The location, scope of service provided, and frequency with which services were available varied across respondent clinics.

PC On Site

Clinic administrators described the PC services available on site at their main mental health clinic to adult consumers with SMI (Table 3.3). Most clinics offered screening or monitoring of PH conditions (72 percent). Approximately half of those clinics (≤36 percent) offered other services (e.g., exams and treatment) on site. PC services were available during most of the work week (M= 4.4, SD=1.4 days per week). At most clinics, PC services were largely available only to their MH consumers and not to individuals otherwise unaffiliated with the clinic (n=19; 86 percent).

Availability of on-site PC services varied by clinic involvement in integrated care initiatives. For example, 100 percent of PBHCI and MI clinics, but only 45 percent of HH clinics, offered screening or monitoring of PH conditions on site. Similarly, physical health exams were available on site at 80 percent of PBHCI clinics and 50 percent of MI clinics but only 27 percent of HH clinics. On-site treatment for acute and chronic conditions was also most common at PBHCI clinics (80 percent) but much less common at MI (17 percent) and HH (27 percent) clinics. Not included in the table but relatedly, PBHCI clinics were more likely to offer HIV/AIDs care (60 percent vs. 17 percent MI and 27 percent HH clinics), and SUD services (60 percent PBHCI and 17 percent MI, 36 percent HH). PBHCI clinics (80 percent) were also more

likely than other clinic types (MI 17 percent, HH 27 percent) to offer phlebotomy services. Few clinics of any types (<15 percent) offered dental or pharmacy services on site.

Among clinics offering screening and monitoring, and physical health exams on site, approximately two-thirds of PBHCI and MI clinics were typically able to leverage some existing infrastructure to support these PH services (e.g., shared reception, shared waiting). However, rarely (except at PBHCI clinics) were MH and PC provider spaces connected.

Table 3.3. PC Services Available to Adult SMI Consumers On Site at Main Clinic

Service		Screening or Monitoring				Physical Exams				Treatment			
		All (n=22)	PBHCI (n=5)	MI (n=6)	HH (n=11)	All (n=22)	PBHCI (n=5)	MI (n=6)	HH (n=11)	All (n=22)	PBHCI (n=5)	MI (n=6)	HH (n=11)
Available at main clinic (n%)		16 (72)	5 (100)	6 (100)	5 (45)	10 (45)	4 (80)	3 (50)	3 (27)	8 (36)	4 (80)	1 (17)	3 (27)
Loc-ation	Shared reception N (%)	10 (45)	3 (60)	5 (83)	3 (27)	5 (23)	3 (60)	2 (33)	0	4 (18)	3 (60)	1 (17)	0
	Shared waiting N (%)	7 (32)	3 (60)	4 (67)	0	5 (23)	3 (60)	2 (33)	0	4 (18)	3 (60)	1 (17)	0
	Connected provider space	7 (32)	4 (80)	3 (50)	0	6 (27)	4 (80)	2 (33)	0	3 (14)	2 (40)	1 (17)	0
Avail-ability	Days/wk M (SD)	4.4 (1.4)	4.5 (1.0)	4.0 (2.0)	5 (0)	3.0 (2.0)	3 (2)	2.3 (2.3)	5 (0)	3.8 (1.8)	4.3 (1.1)	1 (0)	5 (0)
	Evening/ weekend N (%)	8 (36)	2 (40)	4 (67)	2 (18)	1 (5)	1 (20)	0	0	1 (5)	1 (20)	0	0

NOTE: Rates of treatment for chronic and acute conditions were the same.

PC Off Site

Occasionally, PH services were available to SMI consumers through partner agencies (with which the clinic has a formal contract or memorandum of understanding) at an off-site location. Screening and monitoring, PH exams, treatment of chronic and acute conditions, and SUD services were those most commonly offered off site by formal partner agencies (18–27 percent of responding clinics) (see Table 3.4).

Although numbers are small, we note a few apparent differences between off-site services offered by different clinic types. First, MI clinics, despite being able to offer only a limited scope of PH services on site (as dictated by the parameters of their license), reported no formal relationships with partner agencies, in spite of the fact that those clinics were all part of one or more HHs. Second, only a minority of PBHCI clinics described partnerships with FQHCs—none was reported by MI or HH clinics. The reason for this surprising lack of partnering was not

described. Overall, partnerships with specialty (SUD, HIV/AIDS, pharmacy) and technical (phlebotomy) services were uncommon (not detailed in table; <15 percent), particularly at MI and HH clinics, even though they were less likely than PBHCI clinics to offer PH services on site.

Table 3.4. PC Services Offered Off Site by Partner Organizations

Service		Screening or Monitoring				Physical Exams				Treatment			
		All (n=22)	PBHCI (n=5)	MI (n=6)	HH (n=11)	All (n=22)	PBHCI (n=5)	MI (n=6)	HH (n=11)	All (n=22)	PBHCI (n=5)	MI (n=6)	HH (n=11)
Avail at partner org n(%)		4 (18)	2 (40)	0	2 (18)	5 (23)	2 (40)	0	3 (27)	6 (27)	3 (60)	0	3 (27)
Partner type	FQHC n(%)	2 (9)	2 (40)	0	0	2 (9)	2 (40)	0	0	3 (14)	3 (60)	0	0
	Other health clinic n(%)	2 (9)	1 (20)	0	1 (9)	2 (9)	1 (20)	0	1 (9)	2 (9)	1 (20)	0	1 (9)
	Hospital n(%)	4 (18)	2 (40)	0	2 (18)	2 (9)	1 (20)	0	1 (9)	2 (9)	1 (20)	0	1 (9)
Distance from main clinic (miles) M(SD)		1.6 (2.3)	0.3 (0.4)	n/a	3.0 (2.8)	5.5 (8.9)	0.3 (0.4)	n/a	9.0 (11)	5.1 (8.0)	1.2 (1.6)	n/a	9.0 (11)

NOTE: Rates of treatment for chronic and acute conditions were the same.

Wellness Services

In addition to traditional medical services, administrators described the wellness services available to adult SMI consumers through the main MH clinic. Overall, services were offered by either the MH clinic or its PC partner organization, in either individual or group formats. The most common wellness services offered by MH clinics included SUD support (77 percent), smoking cessation services (64 percent), stress management or relaxation training (55 percent), and educational services related to diabetes, nutrition, and other chronic PH conditions (50 percent). Wellness services were generally made available to consumers on a regular basis. Most wellness services were offered year round, and for multiple hours per week (Table 3.5).

Clinic types varied in the availability of wellness services. Specifically, PBHCI (in particular) and MI clinics were likely to offer wellness services of all types, while wellness services were relatively uncommon (<30 percent) either in HH clinics or at affiliate HH locations. Patterns of wellness service availability were fairly consistent across wellness service types; however, HH clinics were slightly more likely to offer behavioral health–related wellness services (SUD support, smoking cessation, stress management) than PH-related services (diabetes, nutrition, healthy cooking). Of note, wellness services were available for fewer hours per week at MI clinics than at other clinics where the services were offered.

Table 3.5. Wellness Service Availability

Wellness Service	Wellness Service Available	Location		Availability	
		Main clinic (n, %)	Other location (n, %)	Months per year M (SD)	Hours per week
Education:					
Diabetes (n=22)	11 (50)	8 (35)	5 (23)	12 (0)	20 (22)
PBHCI (n=5)	4 (80)	4 (80)	1 (20)	12 (0)	29 (33)
MI (n=6)	4 (67)	2 (33)	2 (33)	12 (0)	9 (7)
HH (n=11)	3 (27)	2 (18)	2 (18)	12 (0)	20 (14)
Nutrition (n=22)	11 (50)	9 (41)	5 (23)	12 (0)	27 (24)
PBHCI (n=5)	4 (80)	4 (80)	1 (20)	12 (0)	31 (31)
MI (n=6)	4 (67)	2 (33)	3 (50)	12 (0)	19 (27)
HH (n=11)	3 (27)	3 (27)	1 (9)	12 (0)	30 (13)
Other chronic PH condition (n=22)	11 (50)	9 (41)	3 (14)	12 (0)	33 (37)
PBHCI (n=5)	4 (80)	4 (80)	1 (20)	12 (0)	44 (53)
MI (n=6)	4 (67)	2 (33)	1 (17)	12 (0)	11 (9)
HH (n=11)	3 (27)	3 (27)	1 (9)	12 (0)	40 (27)
Healthy cooking (n=22)	6 (27)	6 (27)	0	10 (5)	16 (19)
PBHCI (n=5)	3 (60)	3 (60)	0	8 (6)	14 (23)
MI (n=6)	1 (17)	1 (17)	0	12 (0)	2 (0)
HH (n=11)	2 (18)	2 (18)	0	12 (0)	28 (17)
Smoking cessation (n=22)	14 (64)	11 (50)	8 (36)	12 (0)	34 (43)
PBHCI (n=5)	5 (100)	5 (100)	2 (40)	12 (0)	42 (46)
MI (n=6)	4 (67)	2 (33)	3 (50)	12 (0)	3 (2)
HH (n=11)	5 (45)	4 (36)	3 (27)	12 (0)	58 (59)
Stress management/ relaxation training (n=22)	12 (55)	11 (50)	3 (14)	11 (3)	27 (36)
PBHCI (n=5)	3 (60)	3 (60)	1 (20)	12 (0)	24 (35)
MI (n=6)	4 (67)	3 (50)	2 (33)	12 (0)	18 (29)
HH (n=11)	5 (45)	5 (45)	0	10 (4)	39 (53)
SUD support (n=22)	17 (77)	13 (59)	10 (45)	12 (2)	43 (49)
PBHCI (n=5)	5 (100)	4 (80)	3 (60)	12 (0)	77 (64)
MI (n=6)	6 (100)	4 (67)	4 (67)	11 (3)	20 (24)
HH (n=11)	6 (55)	5 (45)	3 (27)	12 (0)	33 (39)

NOTE: Totals may be more than 100 percent, since respondents could “check all that apply”. Denominators are specified in table rows.

Staffing and Care Team

Integrated care for MH consumers is necessarily provided by multidisciplinary teams, and clinic administrators reported the number and type of staff employed by respondent MH clinics.

Overall, MH staff was largely licensed practitioners and PC providers were physicians and NPs, supported by RNs/LPNs and MAs. In contrast, CM/CCs, peer and wellness specialists were employed by fewer total clinics.

Clinics' PC staff varied by clinic type. Specifically, among PBHCI clinics, 60 percent employed PCPs, 80 percent employed NPs/Pas, and 40 percent employed RNs. MI clinics were less likely to employ PCPs (17 percent) and NPs/PAs (33 percent), although they were more likely to employ RNs (83 percent). The proportion of HH clinics employing any kind of PC provider was low (9 percent PCP, 9 percent NP/PA, 27 percent RN). Although the number of clinics reporting staff FTE precluded division by clinic type, we note that peer staff members were employed almost exclusively by PBHCI clinics (i.e., grant-funded programs with explicit encouragement to include peers).

Care Management and Care Coordination (CM/CC)

Care management and coordination services (i.e., individualized support to help consumers navigate health and/or social service resources) are a major focus of NYS's Medicaid HH and are a core service of PBHCI; they are not supported through NYS's MI program. Persons providing CM/CC services can have diverse expertise, coming to the profession with MH, medical or nonprofessional backgrounds, and they may be employed by the MH agency, by a specialist CM/CC agency, or another employer.

Administrative respondents noted that the CC/CM staff that they work with are largely employed by MH agencies (n=15; 68 percent) with a minority employed by CM/CC (n=4; 18 percent) or other agencies (n=3; 14 percent).

Individual CM/CC providers (n=5) described their educational backgrounds as including either an associate's degree (n=1, 20 percent) or bachelor's degrees (n=4, 80 percent), and that they were largely nonspecialized (n=4, 80 percent), although one respondent had expertise in both HIV/AIDs and SUD (n=1, 20 percent).

Target Population and Consumers Served

Administrators reported that, over the past year, MH clinics served a total of M=5,206 (SD = 18,969) unduplicated consumers (of any age, diagnosis). Among those, 21 percent (M=1,112; SD = 2,629) were adults with SMI, all of whom were eligible to receive PC services provided or coordinated by the main clinic; that is, clinics did not report additional eligibility criteria, or criteria for targeting PC services beyond adults with SMI.

Clinics involved in the various integrated care initiatives ongoing in the state varied by the size of the SMI adult populations they serve. Overall, PBHCI clinics served more adult SMI

consumers (M=3,153, SD=4,793) than the other two clinic types (MI clinics, M=629, SD = 531; HH clinics M=447, SD= 421), which were similar in size.

The insurance status of adult SMI consumers served at respondent main clinics had Medicaid only (50 percent), Medicaid and Medicare (dual-eligible; 20 percent), Medicare only (14 percent), private insurance (10 percent), or no insurance (6 percent). Administrators reported that approximately 100 percent of their adult clients with SMI were currently eligible for HHs but that only 11 percent were currently enrolled. In short, administrators reported that there is still considerable opportunity for clinics to connect their consumers with HHs. Indeed, the majority of clinics surveyed (n=14; 64 percent) indicated that fewer than 50 percent of their adults with SMI were currently receiving CM/CC services for integrated care, and rates of consumers receiving CM/CC services did not appear to differ by clinic type.

The proportion of consu clinics mers involved in CM/CC services varied by clinic participation in integrated care initiative type. Specifically, 0 percent of MI, 18 percent of HH, and 60 percent of PBHCI clinic respondents indicated that 50 percent or more of their SMI adult consumers receive CM/CC for integrated care services.

Assessment of PC Needs

Table 3.7 illustrates the number of clinics offering basic through comprehensive integrated PH services to adults with SMI (either on or off site) as part of the regular clinical work flow. Survey data showed that the provision of PC in MH clinics starts at intake in most clinics, with 91 percent of clinic administrators reporting that consumers are asked if they had a PC provider during the intake process. Few clinics, however, had additional, routinized assessments to learn more about consumers' connections to PC, such as asking consumers if they are comfortable with their current PC provider (n=5; 23 percent) or if consumers were interested in receiving PH services provided or coordinated by the main clinic (n=6; 27 percent). Overall, assessment of consumer PC needs did not vary by clinic type, with the exception that PBHCI clinics were more likely to routinely and explicitly offer PC services to consumers.

Table 3.7. Assessment of Consumer PC Needs, by Clinic Type

		Clinic Type		
N (%)	**Overall n=22**	**PBHCI n=5**	**MI n=6**	**HH n=11**
PC provider?	20 (91)	4 (80)	6 (100)	10 (91)
Comfortable w PC provider?	5 (23)	1 (20)	1 (17)	3 (27)
Interested in PH services provided/coordinated by main clinic?	6 (27)	3 (60)	2 (33)	1 (9)

Role of CM/CCs in Clinical Work Flow

Administrators also described the role and responsibilities of CM/CCs in integrated care provided or coordinated by the main clinic (Table 3.8). According to administrators, CM/CCs did not typically have a caseload of adults with SMI (n=3; 60 percent). Among those with a caseload (n=2; 40 percent), however, caseloads were highly variable, ranging in size from 18–70 individuals. More data are needed to better quantify a typical CM/CC caseload in NYS.

CM/CCs' tasks, as described by administrators, included monitoring consumer needs, barriers, and progress (73 percent), helping consumers access PC and specialist services (86 percent), accessing social support services (86 percent), managing referrals to specialists (73 percent), and enrolling consumers in health benefits (82 percent).

Administrators from PBHCI clinics were more likely than others to rely on CM/CCs to perform a number of MH and PC-related functions, such as developing treatment plans, educating consumers and families about MH and PH conditions and treatments, managing information about consumer hospitalizations and referrals to specialists, providing psychotherapy, and adhering to medications and treatment plans. In general, administrators from MI clinics described the most limited role for CM/CCs in consumer care.

Of note, when CM/CCs described their responsibilities themselves (provider survey; n=5 respondents), they offered a slightly different perspective on their daily activities, focusing mainly on facilitating communication between PC and MH providers (100 percent) and helping consumers gain access to PC, medical specialist, and social services (80 percent, each). We note that during site visits (Chapter Two), staff at MH clinics often reported working routinely with CM/CCs who were employed not by the mental health clinic but by another HH lead agency, and the experience of those CM/CCs may not be well represented by the survey data described here. It may also be a reason for the comparatively low (e.g., vs. MH providers) CM/CC response rate.

Table 3.8. CM/CC Services and Responsibilities, by Clinic Type

CM/CC Services	Administrator n (%) n=22	Clinic Type		
		PBHCI n=5	MI n=6	HH n=11
Assess and monitor consumer health needs, barriers, and progress	17 (73)	5 (100)	4 (67)	8 (73)
Develop treatment plans	11 (50)	4 (80)	2 (33)	5 (45)
Educate consumers and/or family members about				
MH conditions/treatment	14 (64)	5 (100)	3 (50)	6 (55)
PH conditions/treatment	13 (59)	5 (100)	2 (33)	6 (55)
Facilitate communication b/w MH and PC providers	14 (64)	4 (80)	3 (50)	7 (64)
Help consumers access:				
PC and specialist services	19 (86)	5 (100)	5 (83)	9 (82)
Social support services	19 (86)	5 (100)	5 (83)	9 (82)
Health benefits	18 (82)	5 (100)	4 (67)	9 (82)
Manage:				
Information about consumer hospitalizations	11 (50)	4 (80)	2 (33)	5 (45)
Referrals to specialists	16 (73)	5 (100)	3 (50)	8 (73)
Provide brief structured psychotherapy	6 (27)	3 (60)	1 (17)	2 (18)
Support clinicians to comply with medication guidelines	11 (50)	3 (60)	1 (17)	7 (64)
Support consumers to adhere to treatment plans	15 (68)	5 (100)	2 (33)	8 (73)
Other	4 (18)	0	1 (17)	3 (27)

Health Information Technology (HIT)

HIT can facilitate the provision of integrated care services; however, the scope and functionality of clinics' HIT systems often vary. In this section, we report how administrative respondents described their main clinic's HIT infrastructure, and how and by whom it is used to support clinical care.

Electronic Health Records (EHRs)

Clinic administrators described the type of information integrated into the main clinic's client health record. Overall, records included MH (n=18; 82 percent), SUD (n=13; 59 percent), PC (n=11; 50 percent), and pharmacy (n=10; 45 percent) information. These data suggest that further integration of information in consumer health records may help facilitate the provision of integrated care at respondents' main clinics.

Most clinic health records (n=20; 91 percent) were EHRs. Among those, 9 (45 percent) of EHRs included both MH and PH information. In 35 percent (n=7) of clinics with an EHR, the EHR was also linked to the RHIO. Clinic EHR was associated with clinic type. Specifically, 100 percent of NYS PBHCI clinics reported having integrated EHRs. Indeed, PBHCI grantees may have received $200,000 to enhance and integrate their existing EHRs, in addition to the PBHCI grant. All (100 percent) MI clinics also had EHRs, only 33 percent of which contained MH and PC information. Finally, 82 percent of HH clinics had EHRs, and 18 percent contained both MH and BH information.

CM/CC records were, in half of cases (n=11; 50 percent), in electronic systems. Most often, however, CM/CC electronic records were maintained in a separate system (n=6; 54 percent of 11 electronic systems) not linked to the main clinic EHR. In other words, to facilitate care coordination and management, CM/CC providers toggle between, and consolidate information from, multiple systems.

Clinical Registries

In addition to EHRs, clinics may also have clinical registries—a collection of clinical information (e.g., diagnoses, individual service use encounters) that can be used to track, monitor, deliver, and improve core services for a specific group of consumers. A clinical registry can be paper-based or electronic. Some EHRs also function as clinical registries insofar as they can generate lists of all consumers with a specific diagnosis.

Half of administrator respondents indicated that their clinic had a clinical registry for documenting PC or MH conditions and/or use of these services for individual consumers. Of these registries, nine (41 percent) were electronic and integrated with EHRs, and two (9 percent) were electronic but not integrated. Electronic registries were structured and searchable (i.e., can generate lists of consumers) for the following conditions: allergies (including medication and adverse reactions; n=9, 41 percent); blood pressure (with date of update; n=9, 41 percent); height and weight (n=10, 45 percent); tobacco use status (n=11, 50 percent); diabetes (n=9, 41 percent); and hypertension (n=9, 41 percent). Single respondents indicated that their registries were also searchable for BMI, SUD, hyperlipidemia, vision status, other medical conditions, or all variables in the record (via crystal reports).

Clinical registries were a core component of the PBHCI grants program, and 80 percent of PBHCI grantee clinics reported that a clinical registry for adults with SMI was in place. In contrast, registries were not recommended or required features of either HHs or the MI programs, and 45 percent of HH clinics and 33 percent of MI clinic administrator respondents indicated that their main clinics had clinical registries for adults with SMI.

Use of Data to Provide or Coordinate Physical Health Care Services

Administrators also described how their main clinics used data to provide or coordinate physical health care services for adults with SMI (Table 3.9). Most commonly, clinics used data

to provide follow-up care after hospitalizations or ED visits (73 percent), monitor medications and prevent medication interactions (68 percent), and generate lists and follow-up with consumers not recently seen by the program (50 percent). Fewer than half of administrators indicated that main clinic staff used data reliably to remind clinicians about consumer preventive care needs, track attendance at referral appointments, and to share hospitalization and medication information with partners and external facilities. Although few clinics reported using data to provide or coordinate care, thereby precluding analyses by clinic type, we tentatively observed a trend for PBHCI clinics to use data more widely, particularly for monitoring and coordinating medications.

Table 3.9. Use of Data to Provide or Coordinate Physical Health Care for Adults with SMI

Always or almost always (n, %)	Overall n=22	Clinic Type		
		PBHCI n=5	MI n=6	HH n=11
Electronic system reminds clinicians about consumer preventive care needs at the time of the consumer visit	4 (18)	2 (40)	1 (17)	1 (9)
Consumer information is used to generate lists and follow-up with consumers not recently seen by the program	11 (50)	4 (80)	3 (50)	4 (36)
Lab tests are tracked until results are available, and flagged and followed up with if results are overdue	8 (36)	3 (60)	3 (50)	2 (18)
Consumer attendance at referral appointments is tracked	8 (36)	4 (80)	0	4 (36)
An electronic system is used to monitor medications and prevent medication interactions/incompatibility	15 (68)	5 (100)	4 (67)	6 (55)
Consumer medications are managed with an electronic system accessible by formal partner organizations	6 (27)	3 (60)	2 (33)	1 (17)
Consumer medications are managed by an electronic system accessible by other non-partner organizations	6 (27)	4 (80)	1 (17)	1 (17)
Clinic obtains consumer care summaries from hospitals or other external facilities	10 (45)	2 (40)	3 (50)	5 (45)
Clinic provides follow-up care for consumers after hospitalizations or emergency department visits	16 (73)	5 (100)	4 (67)	7 (64)

Performance Monitoring

State and local data resources are available to help clinics monitor the quality of the integrated services they provide. Administrative respondents indicated that they were using several of these sources, including PSYCKES (n=18; 82 percent) and RHIOs (n=7; 32 percent) to monitor program performance or to deliver care. Fewer respondents reported using other data

systems (n=3; 14 percent) such as internal CQI datasets (n=1; 5 percent) and state controlled drug registries (n=2; 9 percent) for these purposes. Notably, however, only a minority of respondents indicated that they used data to monitor the quality of preventive care (n=5; 23 percent), quality of treatment for chronic or acute conditions (n=6; 27 percent), and program costs (n=4; 18 percent) throughout the year (i.e., at least quarterly). Data on performance monitoring were insufficient to present by clinic type.

Provider Perspectives on HIT

The usefulness of EHRs is limited if key staff is unable to access all of the information needed to provide integrated care. According to providers, ability to access and contribute to records across specialties was limited (Table 3.10). Fewer than 45 percent of MH providers had access to SUD or PC records, and ability to contribute to or change these records was less (19 percent and 15 percent, respectively). On the other hand, while 100 percent of PC providers could access MH records, only 33 percent could contribute to them, and 33 percent of PC providers could access or contribute/change SUD records. Finally, CM/CC access to records of all types was common (60–80 percent), despite rates of ability to contribute or change being low (20–40 percent) across record types.

Table 3.10. Provider Access and Ability to Contribution to Health Records, by Provider Type

Health Record N (%)	Overall n=34	PC n=3	MH n=26	CM/CC n=5
Access				
MH	28 (82)	3 (100)	21 (81)	4 (80)
SUD	14 (41)	1 (33)	10 (38)	3 (60)
PC	17 (50)	3 (100)	11 (42)	3 (60)
Other	3 (9)	0 (0)	3 (11)	0 (0)
Contribute to or change				
MH	24 (71)	1 (33)	21 (81)	2 (40)
SUD	7 (21)	1 (33)	5 (19)	1 (20)
PC	9 (26)	3 (100)	4 (15)	2 (40)
Other	4 (12)	0 (0)	4 (15)	0 (0)

Providers also indicated which sources of information they use to determine whether an adult consumer with SMI, who receives PH services provided or coordinated by the main clinic, has been hospitalized. Overall, providers were most likely to use EHRs for this purpose (n=21; 62 percent); this was true at similar rates across provider types (PC 67 percent; MH 58 percent, CM/CC 80 percent). Subsets of providers also used HH databases (15 percent) or RHIOs (12

percent) to get this information. Only MH providers (31 percent) indicated that they had no means of getting hospitalization information other than asking consumers directly.

Lastly, providers described how their main clinic used data for quality improvement (Table 3.11). In general, while more than 60 percent of provider respondents indicated that they received productivity or performance reports about work in the main clinic, the kinds of information individuals received varied by provider type. Specifically, MH providers were likely to receive personalized productivity reports (50 percent), while PC providers received personalized performance reports (100 percent). None of the CM/CC respondents reported receiving either of these types of individual-level activity reports.

Table 3.11. Use of Data for Quality Improvement

Receive productivity or performance reports about work in the main clinic?	Overall n=34	PC n=3	MH n=26	CM/CC n=5
Yes n (%)	21 (62)	3 (100)	16 (62)	2 (40)
If so, what types of reports do you receive?				
Personalized productivity reports	14 (41)	1 (33)	13 (50)	0 (0)
Personalized performance reports	4 (12)	3 (100)	1 (4)	0(0)

Culture of Integration

Recent research suggests that interdisciplinary provider communication and collaboration is important for promoting consumer access to integrated services (Scharf et al., 2014). In this section, we describe provider experiences communicating and collaborating with different members of the care team.

Overall, respondents across provider types generally reported communicating and collaborating with one another on treatment plans (range >65 percent), and that, in general, MH and PC providers trust and respect one another (>60 percent) and work comfortably together, approaching consumer care with a sense of partnership and shared decisionmaking (>55 percent). They also reported that leadership is generally effective at promoting integrated care (65 percent) (Table 3.12). Although small numbers make interpreting between-clinic type differences difficult, we tentatively note that PBHCI and MI clinics reported stronger MH and PC relationships at the provider and administrator level than HH clinics, and that PBHCI clinic staff may be more likely than other clinic staff to have regular, positive interactions in the clinic setting.

Table 3.12. MH-PC Relationships, by Clinic Type

		Clinic Type		
Agree or strongly agree (n, %)	**Overall n=34**	**PBHCI n=4**	**MI n=13**	**HH n=17**
MH providers and PC providers:				
Trust each other	21 (62)	3 (75)	10 (77)	8 (47)
Respect each other	25 (74)	3 (75)	11 (85)	11 (65)
Work comfortably together	20 (59)	3 (75)	10 (77)	7 (54)
Have regular, positive interactions in our clinic	17 (50)	3 (75)	7 (54)	7 (54)
Approach consumer care with a sense of partnership and shared decisionmaking	19 (56)	3 (75)	9 (69)	7 (54)
Our leadership is effective at promoting integrated physical and mental health care	22 (65)	3 (75)	9 (69)	10 (59)

Summary

Participating clinics were alike in several key ways: Virtually all participating mental health clinics were HH affiliated, and with more than one HH. Clinics of all types generally offered on-site screening and monitoring of physical health conditions. At most clinics records were maintained in an EHR, although few of these were integrated with PC and CM/CC notes. Providers of all disciplines described closer collaborative relationships at clinics offering a broader scope of physical health services on site (even when the scope of these services was limited, as in Medicaid Incentive clinics), suggesting that providers who work together in the same space may have more opportunities to build trust and respect related to the provision of integrated care.

Clinics participating in each of the three project initiatives also had distinctive features. Overall, PBHCI clinics were more likely to be in urban settings serving larger numbers of SMI adults. PBHCI clinics were more likely to be hospital affiliated, likely facilitating access to medical services and other infrastructure including HIT. Indeed, PBHCI clinics were more likely to report using registries to support clinical care. PBHCI clinics were more likely than other clinic types to have obtained (on their own or via a partner organization) a Department of Health (Article 28) license to provide comprehensive, on-site primary care. Licenses and availability of grant funding also affected staff membership on the care team: PBHCI clinics were more likely to employ case managers, peers, and wellness specialists. PBHCI clinic administrators described a broader role for case managers than at other clinics, and perhaps relatedly, PBHCI clinic staff

also reported greater success enrolling consumers in integrated care initiatives, including Health Homes.

In contrast, Medicaid Incentive clinics tended to be smaller, freestanding (non–hospital-affiliated) entities. Medicaid Incentive clinics provided only the limited scope of primary care services (health monitoring, health physicals) permitted by their licenses. Participation in the incentive did not typically alter clinic infrastructure (e.g., record systems, physical space) or membership on clinics' care team. For instance, primary care services were often provided by existing mental health staff (e.g., psychiatric nurses provided the primary care). Medicaid Incentive clinic administrators also reported a comparatively narrow role for case managers in consumers' overall care.

Finally, mental health clinics participating in Health Homes but not PBHCI or the Medicaid Incentive program were varied, including academic medical center-affiliated clinics and freestanding clinics of varying resources, capabilities, and size. Among these clinics, overall, we observed that participation in the Health Home did not alter the clinic's scope of practice. As intended by the program, participation in Health Homes appeared to be associated with increased reliance on case managers and networks of agencies to get consumers access to primary care.

Research Question 2: Policy Impacts

In this section, we report data illustrating how clinic administrators, providers, and their consumers (as reported by staff survey respondents) may be impacted by the policies shaping the three different approaches to integrated care. We begin with providers' perspective on integration, since it includes individuals' opinions on the services and policies already in place.

Provider Perspectives on Integrated Care Policy

Providers from clinics across initiatives reported believing that their clientele were experiencing improved PH and MH outcomes as a result of their clinic's participation in integrated care, and concerns about increases in caseload and administrative burden were moderate across clinic types, although workload increases appeared slightly higher within PBHCIs.

At the same time, providers at different clinic types reported differences in the impact of initiatives on consumers' access to care. Specifically, while PBHCI-affiliated providers unanimously reported that the grants improved consumer access to PC and medical specialists, similar improvements in access to PC and specialists were reported by only half or one quarter of MI and HH respondents, respectively. Providers at PBHCI clinics also generally reported that the grants improved consumer access to social services, while providers at HH clinics were less likely to report this trend.

Finally, while PBHCI and HH providers were generally likely to indicate that they had received adequate training to support changes in work responsibilities (both initiatives are

supported by formal technical assistance centers offering provider training), such training appeared to occur less often at MI clinics for which no similar technical assistance center exists.

Table 3.12. Provider Perspectives on Integrated Care Initiative Policies

Agree or Strongly Agree, n (%)	Overall n=16	PBHCI n =3	MI n=9	HH n=4
My consumers have better access to PC	9 (56)	3 (100)	5 (56)	1 (25)
My consumers have better access to medical specialists	8 (50)	3 (100)	4 (44)	1 (25)
My consumers have better access to social services *	3 (43)	2 (67)	N/A	1 (25)
Information sharing outside of the clinic *	3 (43)	2 (67)	N/A	1 (25)
Improve access consumer information from outside of our clinic*	1 (14)	0 (0)	N/A	1 (25)
Better consumer PH outcomes	14 (88)	3 (100)	7 (78)	4 (100)
Better consumer MH outcomes	15 (94)	3 (100)	8 (89)	4 (100)
My caseload has increased	1 (6)	0 (0)	1 (11)	0 (0)
My administrative burden has increased	5 (31)	1 (33)	2 (22)	2 (50)
My work responsibilities have increased	8 (5)	2 (67)	4 (44)	2 (50)
I received training that was sufficient to prepare me for my work responsibilities	10 (63)	3 (100)	4 (44)	3 (75)

NOTE: Overall N for these questions is 7 instead of 16, since MI clinics didn't answer these questions. N's are total providers who accurately described their clinic's participation with each integrated care initiative.

Administrator Perspectives on Integrated Care Policies

Administrators also described the impact of integrated care policies by ranking their top five unresolved challenges to integration occurring at their main clinic. Approximately half of administrators (40–55 percent across clinic types) ranked infrastructure challenges related to acquiring and modifying physical space to accommodate PH services (50 percent), and acquiring and arranging for transportation for consumers (33–45 percent), as problematic. Administrators also ranked administrative challenges such as hiring (80 percent PBHCI, 50 percent MI, and 27 percent HH) and data reporting and administrative burden (40 percent PBHCI, 83 percent MI, 55 percent HH) as problematic.

Clinics of different types, however, differed considerably on their challenges related to clinical processes, and the most commonly ranked policy-related challenge to integration—financial sustainability (PBHCI and MI, 100 percent, HH 55 percent). In what follows, we detail clinics' clinical challenges and then, separately, challenges to sustainability.

Policy Impacts on Clinical Processes

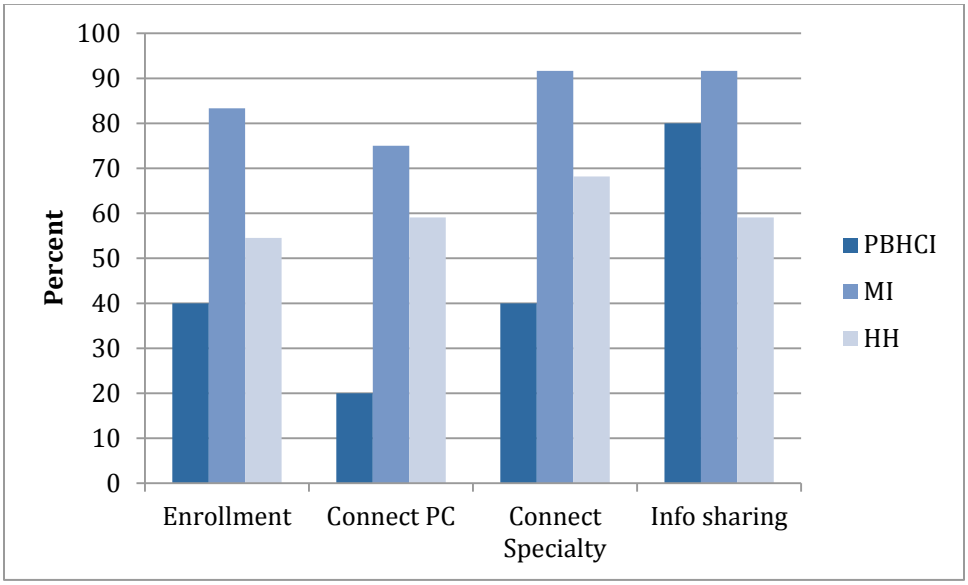
Administrators from PBHCI grant-funded programs reported that the most common challenges to their clinical care were hiring (80 percent) and information sharing, while enrolling consumers in integrated care and connecting them to services were challenges for only a

minority of respondents. The only challenge endorsed by more than half of PBHCI administrators was information sharing outside of the clinic (60 percent). Challenges to care reported by other clinic types were endorsed at very low rates by administrators at PBHCI-funded clinics.

Among administrative respondents from clinics participating in the MI initiative, respondents (>70 percent) described challenges to integrated care including maintaining adequate consumer volume, hiring, scheduling, and sharing clinical information with providers outside of the main clinic (Figure 3.4). They also noted challenges connecting consumers to resources (>70 percent) and, in particular, connecting consumers to specialty medical care (91 percent).

All respondent clinics were either lead or participant agencies in NYS's Medicaid HH initiative. Consequently, administrators from all clinics provided information on the impacts, successes, and challenges of HHs (Figure 3.1). More than half of administrators reported minor or major challenges with enrollment and contacting HH referrals from the state. In general, information sharing outside of the main clinic was perceived as a common but minor barrier. For consumers already enrolled in HHs, administrators were likely (>59 percent) to report minor or major challenges with connecting consumers to PC, specialty, and social services, including making connections to providers perceived to treat their consumers with respect. Importantly, although less than half (41 percent) of administrators indicated that data and reporting requirements were a challenge, many of those who did perceived it as a major challenge to the delivery of integrated care for adults with SMI.

Figure 3.4. Administrator-Reported Challenges to Integrated Care, by Initiative



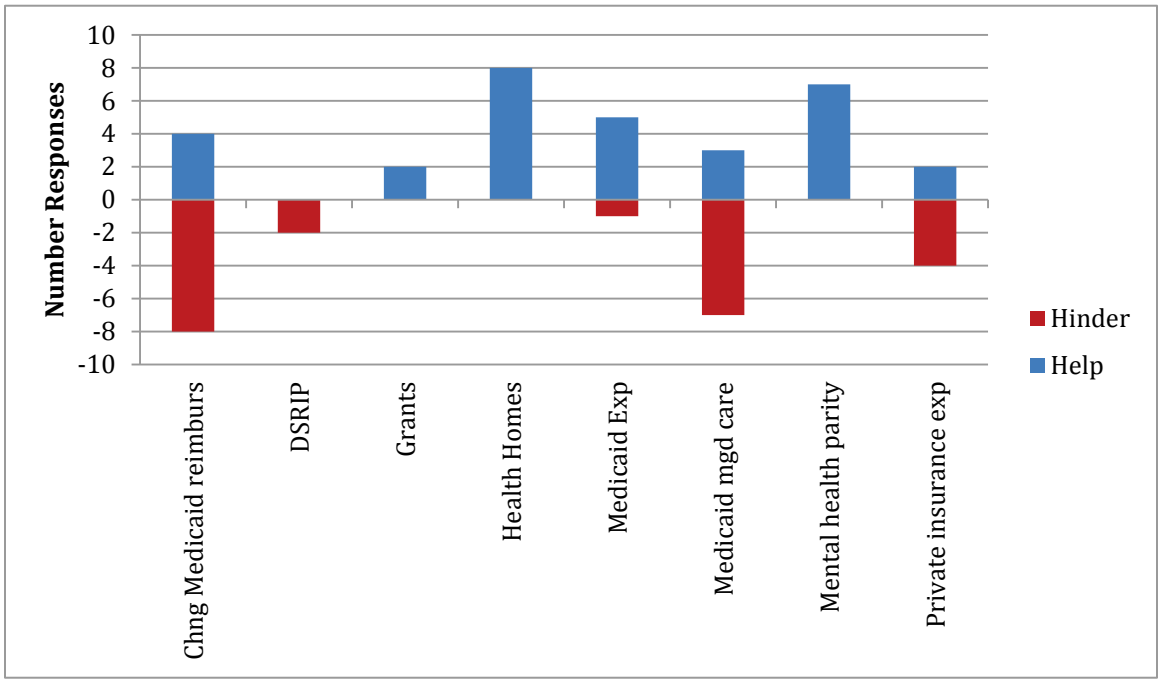
NOTE: HH data in the figure include responses from all clinic administrators, because respondents were asked to describe challenges to integrated care specific to participation in each initiative in which the clinic participates.

Financing and Sustainability

As above, financing and sustainability was a top concern for survey respondents. Administrators' plans for long-term financial sustainability of integrated care included clinic changes in operation and work flow (e.g., obtain expanded licensing, n=4; provide more PC by increasing clinic census or providing more consumer PC visits, n=5; find a PC partner, n=1) but also depended heavily on forthcoming policy opportunities. Specifically, clinics planned to keep up with new billing opportunities (n=1), increase reimbursement through outcomes-driven reimbursement (capitation) (n=3), apply for grants (n=2), and hope for increased reimbursement (n=1). Two (n=2) respondents did not have a financial sustainability plan.

Administrative respondents also described their beliefs about which various federal, state, and local initiatives may be influencing their clinics' ability to sustain integrated PH care in the MH setting (Figure 3.3). Few respondents reported opinions about the specific impacts of forthcoming initiatives. Among those who did, however, respondents indicated that grants, HHs, Medicaid expansion, and mental health parity were expected to help with the sustainability of integrated care, while opinions about changes in Medicaid reimbursement, Medicaid managed care, and private insurance expansion were mixed, with some respondents anticipating negative and positive impacts. Although only two respondents indicated having an opinion about Delivery System Reform Incentive Payment (DSRIP), both anticipated that it would harm the sustainability of MH-based integrated care. Data on perceived impacts of initiatives were insufficient to analyze by clinic type.

Figure 3.3. Perceived Impact of Initiatives on Financial Sustainability of Integrated Care



Summary

Overall, providers reported that their clinic's participation in integrated care, regardless of initiative, was improving consumer PH and MH outcomes, with only moderate increases in administrative burden and workload (although these increases were somewhat higher in PBHCI than other clinic types). However, responses to questions about ongoing challenges to programs suggest a number of areas in which opportunities to improve the policies shaping NYS's integrated care for adults with SMI may exist.

For example, administrators reported that creating infrastructure to support integrated care, and meeting administrative burdens of the program, were challenging. Issues related to hiring qualified personnel were also raised and are consistent with broader challenges related to provider shortages and known challenges of incentivizing medical providers to treat adults with SMI. Clinics' long-term integrated care financial sustainability plans depended heavily on forthcoming policy opportunities that might increase sources of revenue from, for example, HHs, Medicaid expansion, and mental health parity. At the same time, they had concerns that other policy initiatives would negatively impact their bottom line (e.g., Medicaid reimbursement, Medicaid managed care, private insurance expansion, DSRIP). These concerns may be justified in the face of forthcoming changes to payment in the state from HARPS and DSRIP; we also note that these concerns were echoed in our ongoing discussions with experts and stakeholders throughout the project period.

In addition to the overall trends described above, the degree and frequency with which challenges were endorsed across clinic types varied. Briefly, administrative respondents from PBHCI clinics described few challenges beyond hiring and information sharing outside of the main clinic; program challenges reported by other clinic types were endorsed at very low rates. In contrast, administrative respondents from MI clinics were likely to endorse challenges related to a wide variety of domains, including maintaining adequate consumer volume, hiring, scheduling, and sharing clinical information with providers outside of the main clinic, connecting consumers to resources, and, in particular, connecting consumers to specialty medical care. Strategies to improve consumer connections to specialty care may require further policy intervention, since most current initiatives focus on connections to PC, and many consumers with identified PH needs require care for severe and complex presentations of disease. Finally, all respondent clinics commented on challenges specific to HH participation. HH-specific challenges were related to enrollment and contacting HH referrals from the state. In general, HH clinics were also challenged to share information outside of the main clinic and connect consumers to medical and social services. Unlike PBHCI or MI clinics that likely referred the majority of their consumers to a small number of PC providers familiar and willing to work with the population, HH participants also expressed concerns about linking their consumers to providers who would treat them with respect.

Research Question 3: Innovations

A structured survey is an imperfect tool for capturing the essence of emerging innovations in integrated care delivery and finance. In this section, we report respondent suggestions for improvements to state policies and practices that reflect their ongoing or preferred approaches to the delivery of integrated MH and PC services for adults with SMI. Unfortunately, few respondents completed these survey items. Nonetheless, we briefly describe the short list of ideas put forth: Respondents requested changes in licensing requirements for the provision of integrated care, including general requests for improvements and streamlining the integrated licensing process (n=6), certification for peer specialists (n=1), improved flexibility for NPs to provide a broader scope of service (e.g., medication management and psychotherapy) (n=1), increased billing opportunities for services (e.g., care coordination, peer specialists, wellness services) (n=3), and reduced or eliminated caps to medical billing in behavioral health settings (n=1).

Clinic administrators also requested better coordination of integrated care initiatives by the state. Specifically, respondents noted that there are multiple initiatives to promote integrated care and better coordinate care but that those initiatives are not coordinated, putting the burden of meeting requirements and maximizing benefits for patients on the clinics; clinics request that these issues be resolved at the level of government instead (n=3). One respondent noted that the OASAS integrated license could be used as a model for a similar OMH-DOC license.

Finally, respondents (n=15) provided a number of suggestions for how reimbursement for integrated care services could be improved. These included raising reimbursement rates, equating reimbursement rates for similar services provided at Article 31 and 28 clinics, restoring Medicaid reimbursement rates to prior levels, linking reimbursement to outcomes (as opposed to fee for service), providing equal reimbursement mechanisms for health monitoring, smoking cessation, and care coordination for consumers provided by MH and PC staff, and increasing the number of third-party payers.

Summary

A small number of respondents made suggestions for improvements to state policies and practices to facilitate their clinics' ongoing or desired approaches to the delivery of integrated PH services for adults with SMI. Overall, respondents requested that the integrated licensing process be made more efficient and that there be better coordination of integrated care initiatives between state agencies, relieving clinics of the burden of identifying and resolving conflicting requirements from DOH and OMH. To support sustainability of integrated care, respondents requested reimbursement that supports new (e.g., peer, wellness) or changing (e.g., case manager) roles of staff consistent with quality integrated services, and that reimbursement be equitable whether PC services are provided in the MH or PC setting.

Chapter Four. Summary and Recommendations

Throughout this report, we describe NYS's MH clinics' experiences providing or coordinating integrated PC for adults with SMI. As noted throughout the report, our research has some limitations, including small sample sizes and limitations of the representativeness of the sample, the qualitative nature of the research, and the omission (though a strategic decision) of the experiences of clinics not providing integrated care. Nonetheless, this report makes a number of contributions to the current research and policy literature. First, we describe the experience of SAMHSA's federal PBHCI grant program, with multiple, diverse sites operating in a single policy environment. This information may be useful to federal policymakers attempting to understand whether the PBHCI model works equally well across states and their unique policy environments. This report also describes the first independent research (i.e., not produced by the OMH) on NYS's Medicaid Incentive program, which aims to promote MH-based integrated care by simply creating reimbursement mechanisms for specific PC services. This simultaneous examination of MI and PBHCI creates the opportunity to compare and contrast different payment approaches, levels of investment, and breadth of integrated services that may help policymakers approximate an efficient yet effective investment strategy considering the strengths and limitations of each approach. In addition, although NYS's HHs are being widely investigated, this report describes the first research on MH clinics' early experiences in the HH; this work is particularly important because NYS's HH focuses on the needs of adults with SMI whose gateway into the health care systems is principally through community MH centers. How MH clinics are functioning in the HH may have implications for the extent to which consumers are connected to, and engaged in, HHs. Finally, a unique contribution of this research is that we describe consumers' experiences receiving integrated care through each of the state's ongoing initiatives. Few large-scale evaluations of integrated care initiatives (e.g., those drawing on secondary data sources such as claims data) include consumer perspectives on the value of multiple or any specific approaches to integration; this work is critical to ensure that as policymakers change and shape ongoing programs, they can take active steps to preserve aspects of integrated care programs that consumers value most.

Research Question 1: Shared and Distinctive Features

In this section, we summarize site visit and survey findings in order to answer Research Question 1: *What are the shared and distinctive features of community MH center–based integrated care programs for SMI adults currently operating in New York state?* As throughout the report, we discuss aspects of integrated care clinics and programs separately, including clinic

structures and services, staffing and care team, clinics' target populations for integrated care, work flow, use of HIT, and clinic culture of integration.

Structures and Services

Shared

All participating mental health clinics were Health Home-affiliated and were typically affiliated with more than one Health Home. Clinics of all types offered on-site screening and monitoring of physical health conditions, and at almost all clinics, mental health notes were maintained in an electronic health record; few of these records, however, were integrated (i.e., included primary care information). Case manager/care coordinator notes were almost always maintained in a separate electronic system.

Distinctive

Despite some similarities, participating clinics were quite diverse. Clinics varied in location (urban/suburban/rural), size, and other features, with notable differences between clinics participating in each integrated care initiative. Overall, PBHCI clinics were larger, serving more adults with SMI than other clinic types. PBHCI clinics were more likely to be situated within agencies with a medical hospital affiliation (potentially facilitating access to primary and other medical services, plus other infrastructure to support physical health care such as HIT), and PBHCI clinics were more likely to report using registries to support clinical care (note that clinical registries were a core component of PBHCI). Importantly, PBHCI clinics were more likely than other clinic types to have obtained (on their own or via a partner organization) a Department of Health (Article 28) license to provide comprehensive, on-site primary care, including treatment for physical health conditions (which was rarely offered at other clinic types). Indeed, this finding was expected because, among the three initiatives, PBHCI clinics receive the most direct financial incentives and support to provide a broad scope of services (with accompanying funds to develop infrastructure) directly in the MH setting, and because many PBHCI clinics used grant funds to support the administrative cost of pursuing broad-scope PC licenses, such as Article 28, or the dual or co-license options available in the state.

Licenses and availability of grant funding likely affected staff membership on the care team: PBHCI clinics were more likely to employ case managers, peers, and wellness specialists. PBHCI clinic administrators described a broader role for case managers than at other clinics, and perhaps relatedly, PBHCI clinic staff also reported greater success enrolling consumers in integrated care initiatives, including Health Homes.

Staffing and Care Team

Shared

Clinics' mental health staff largely consisted of licensed practitioners. CM/CC staff typically had bachelors' degrees and were generally nonspecialized (i.e., did not endorse particular MH, PH, SUD, or HIV expertise). We note that MH clinics often reported working routinely with CM/CCs who were not employed by the mental health clinic, but who were employed by another HH lead agency, and the experience of those CM/CCs may not be well represented by the survey data detailed in this report.

Distinctive

Few clinics employed CM/CCs, peers, or wellness specialists, and many of these positions were grant funded. Compared to other clinics, PBHCI grantees were more likely to employ peers, CM/CC, and wellness staff. This finding was somewhat expected because the PBHCI grants encouraged the provision of these services and provided flexible funds that could be used to support these less traditional staff types.

Target Population

Shared

The adult population with SMI served by NYS' MH clinics was generally insured by public payers, with the majority of consumers enrolled in Medicaid only or dually enrolled in Medicaid and Medicare. In general, clinics reported that 100 percent of their adult consumers with SMI were eligible for enrollment in HHs. Regardless of the integrated care initiatives in which clinics were participating, MH clinics generally made their PH services available to all of their adult consumers with SMI; i.e., they did not apply additional eligibility or target criteria for consumers to receive integrated care.

Distinctive

PBHCI clinics tended to serve larger populations of adults with SMI than either HH or MI clinics; PBHCI clinics reported serving SMI populations approximately five times larger than the other sites. These differences could be related to the fact that PBHCI clinics were generally located in the greater New York City area. Alternatively, larger clinics may have been more likely to receive PBHCI grants, demonstrating specific need for PH services for the SMI population. In any case, the number of adult consumers with SMI served across clinics varied, which may have implications for clinic administrators' perceived need to pursue comprehensive DOH licenses for PC and or for sustainability planning (e.g., larger clinics may be more sustainable because of efficiencies created through economies of scale, or because they have a sufficiently large census of consumers to justify employing PC providers full time), among other issues.

Clinics also varied in their ability to enroll consumers in HHs. Overall, PBHCI clinics reported higher rates of consumer enrollment in HHs compared to other clinic types. Several factors could explain this finding. Specifically, PBHCI clinics may have staff and consumers who have already been accustomed to thinking about integrated care and the value of working with networks of providers and agencies, making enrollment in the program seem more intuitive and potentially beneficial. In addition, PBHCI clinics may have greater administrative and CM/CC provider incentive to enroll consumers in HHs as part of their plans to sustain integrated care and CM/CCs positions initially created with grant funds. In any case, this disparity suggests that HH and MI clinics may need additional supports (such as those recently described by Hamblin, Davis, and Hunt, 2014) to increase consumer enrollment in HHs.

Work Flow

Shared

CM/CC activities generally involve facilitating communication between PC and MH providers, and helping consumers connect to PC and medical specialist services. Respondents from clinics of all types described connecting consumers with medical specialists as particularly challenging.

Distinctive

While not readily apparent in survey data, data from site visits suggested that access to, and use of, PC services was much more flexible in PBHCI clinics than in MI clinics. In particular, in PBHCI clinics, consumers could be referred for PC services and seen in the same office on the same day. PC services in MI clinics, however, were very highly regimented. Patients received an initial physical exam or routine tests according to predetermined schedules. In other words, although MI PC providers were operating in the MH setting, their approach to the delivery of PC was not consistent with consumer needs. Whether this discrepancy in approach to PC work flow is related to the maturity or scope of integrated care offered in PBCHI vs. MI clinics is unclear. In any case, technical assistance to MI clinics regarding how PC services may be more flexibly offered may be warranted, and may also be useful for decreasing appointment no-shows and increasing billing opportunities and sustainability. Strategies for increasing clinic census may also be effective for improving program sustainability.

We also observed differences across clinic types in the roles, functions, and expectations of CM/CC staff. For instance, although CM/CCs provided similar services across clinics, administrators from clinics providing PH treatment off-site were more likely to report that CM/CCs were responsible for coordinating consumer medical care (including PC, specialist visits, hospitalizations, communication between MH and PC providers). More specifically, in one setting that we visited, the CM/CC was considered the “head of the care team” and was

broadly responsible for understanding consumers' needs across multiple domains and bringing together providers of different types to ensure that these needs were being met. Another site defined the CC role separately from the CM role, with the CC holding responsibility for scouring all available data sources (e.g., RHIO, PSYCKES, EHR, registries) and feeding information to CMs in the field performing such functions as transportation to appointments and helping consumers adhere to treatment plans. In any case, CM/CCs working in settings with greater needs and expectations for coordination of medical services may require additional medical care–specific training and expertise in order to meet the demands of the job. This need for additional training was substantiated by survey results suggesting that in general, PBHCI clinic staff were more likely than other clinic types to report that they received adequate training to meet integration-related changes in job role.

HIT

Shared

Participating clinics of all types had EHRs. Clinics were likely to use these data to coordinate care following hospitalization or an ED visit, monitor medications and prevent medication interactions, and generate lists and follow-up with consumers not recently seen by the program. Clinics were unlikely to use data reliably to remind clinicians about consumer preventive care needs, track attendance at referral appointments, and to share hospitalization and medication information with partners and external facilities.

Although the functionality and sophistication of clinics' EHRs was varied, challenges related to sharing and accessing information among different provider types on the team was common. In particular, MH providers were largely unable to access PH information, although limits on PC access to MH information were reported, as well. Another widely reported challenge to HIT was the interface between CM/CC systems and the rest of the EHR. CM/CC systems were often separate from the in-house system, and CM/CC providers often had to toggle between multiple systems to access and use the information they needed to support integrated care.

Distinctive

Less consistent across clinics was the presence and use of clinical registries to manage consumer care. Compared to HH and MI clinics, PBHCI clinics were more likely to report having and using registries to manage care. Indeed, clinical registries were a requirement of the PBHCI grants. On the other hand, RAND's evaluation of PBHCI showed that this aspect of the grants program was implemented inconsistently by PBHCI grantees (Scharf et al., 2014), suggesting that New York state's PBHCI grantees may be particularly adept in this regard. Similarly, only one-third of participating clinics had EHRs that interfaced with local RHIO(s). This finding was somewhat surprising given that it was a requirement after 18 months of HH

participation. Strategies for improving HH accountability for core functions may need to be employed.

Culture of Integration

Shared

To some extent the process of selection of clinics ensured that all the clinics we visited were led by administrators or clinicians who place a high priority on providing physical health care for their consumers. Providers from most clinics reported that they work collaboratively across disciplines to create consumer treatment plans, and overall, staff reported that these cross-disciplinary relationships were positive. On the other hand, few staff reported that they attended cross-disciplinary clinical care meetings on a regular basis.

Distinctive

Even though directors of the MI clinics expressed a strong intention to improve primary care services for their consumers, they were not able to make the kinds of changes needed to affect patterns of care at a system level. A pervasive culture of integration, in which different types of providers expect to work together to address physical as well as mental health problems, was apparent (with a few exceptions of innovative HH clinics selected for site visits) predominantly at PBHCI sites. In the MI clinics, PC services had been added as services, but providers were not oriented toward or accustomed to providing integrated care (e.g., developing and executing care plans with input across provider types). The culture shift from providing parallel MH and PC services to integrated services is unlikely to occur simply by colocating services (Scharf et al., 2014). At the same time, providers of all disciplines at clinics offering PH treatment services on site described closer collaborative relationships, suggesting that providers who work together in the same space may at least have more opportunities to build trust and respect related to the provision of integrated care. Perhaps these opportunities can also be strengthened if clinics require regular meetings involving all members from the care team.

Research Question 2: Policy Impacts

Here we summarize site visit and survey findings in order to answer Research Question 2: *What policies or strategies at the initiative/program level, clinic/organization level and provider/clinical level appear to facilitate or impede implementation, operation, and sustainability of each program type and overall?* In particular, we describe clinics' ongoing policy-related challenges to implementing integrated care services.

Implementation and Operation

All three of the policy initiatives examined in this report are being implemented against the backdrop of a fragmented health system that poses numerous challenges to integrated care.

Indeed, these challenges are the primary motivations for providing PC services in MH clinics. The policy initiatives address some but not all of these challenges, and they address them in differing degrees and with different strategies.

Across all clinic types, clinic staff reported struggles to untangle conflicting OMH and DOH infrastructure requirements, often building duplicate spaces or separate doors, and hiring separate staff to support PC services. Clinic staff generally reported resenting having to duplicate resources because of their expense, but mainly because they reinforce silos of MH and PC services instead of integrating them. Similarly, HIPAA and SUD and HIV/AIDS-specific challenges to information sharing were challenges, regardless of which initiative clinics were participating in.

At the same time, clinics that received PBHCI grants were able to apply considerable financial resources to address the challenges of providing integrated primary care services systematically. They were able to hire new staff;, reorganize work flow; promote collaborations between providers within the clinic; provide reliable PC services, wellness services for chronic PH conditions, and peer supports; and hold interdisciplinary case conferences to develop pragmatic strategies for managing the most complex consumer needs. In these clinics, the resources were available to finance a culture change; virtually all staff in the clinic was aware of, and actively participated in, the program. Although the PBHCI grants were not a panacea (e.g., the grants did not resolve longstanding interagency issues or relieve provider shortages in underserved areas—indeed, all NYS PBHCI grantees were located in large, urban settings), in many cases, the grants provided flexible funds that allowed agency staff to invest in specific, identified infrastructure needs (including staff training) to support a broad scope of integrated care.

The overall culture change observed at PBHCI clinics was not observed in the clinics that were using the Medicaid Incentives to provide health physical and health monitoring services. Despite the fact that the administrations of these clinics were equally committed to the same goal, in MI clinics, administrators had been attempting to expand PC services for their patients and were benefiting from the ability to bill for some of these services, but gaining this ability was not a watershed event. Most of the staff was unaware of the billing issues; the PC services were provided as part of a clinic routine, e.g. “seeing the nurse,” and not as part of a systematic shift in approach that involved all providers. Similarly, results of consumer focus groups suggested that consumers were more likely to value PC services that included acute treatment for PH conditions (e.g., headache, stitches), so that they could get all of their routine care in one place. The absence of specific trainings for MH and CM/CC staff to become more aware of consumer PH issues and confident in their ability to assist consumers with PH goals (including established connections with reliable, quality PH treatment services), plus the absence of pronounced consumer enthusiasm for the services, may have resulted in the MI program creating a small scope of sustainable PH services but no clinicwide movement toward integrated care.

While the PBHCI and Medicaid Incentive programs are variations of the same approach, HHs represent a very different approach to integration, focusing on coordinating care within a network of existing providers rather than developing a new or different clinical setting. The HH has the potential to integrate well with MH-based PC services because CC/CMs can provide individualized attention that consumers with complex medical needs require to effectively link multiple medical providers as well as social services (e.g., housing and transportation services) that are also essential to their well-being. Linkage to providers of specialized medical care is particularly important for the MI program, where the ability to refer patients based on findings from a physical exam is essential and currently a major challenge for providers. Administrators and CC/CMs are aware of this potential synergy between the HH and MH-based PC, but they are also apprehensive about the future, given anticipated increases in caseload and reduction in PMPM payments (once legacy payments expire). There is also considerable concern about the inadequacy of medical and social services available in the community, particularly in suburban and rural regions of the state.

Our research suggested that there are other important factors in the success of MH-based PC services that may not be widely recognized:

1. MH clinics benefit enormously from their legacy of close relationships with community-based support systems for adults with SMI, such as the PROS day programs. These programs contribute to making MH clinics into centers not only for clinical treatment but also for community integration for adults who are otherwise socially isolated and stigmatized because of their condition. It is this broader role in the community that makes MH clinics preferred sites for PC services for this population.
2. The newly offered patient information and quality tracking systems, such as PSYKES and the RHIOs, are being used widely and eagerly by clinicians and administrators in many settings. In some settings these systems have already been integrated into practice (including clinics' EHRs), while in others their use is just starting. Based on our interviews, we anticipate continued growth in the use of these systems to coordinate care, even within freestanding behavioral health clinics in relatively rural areas—particularly with continuing technical assistance from the state on the mechanics of how to use the systems, but also on the potential uses of system information to improve care and CQI.
3. Information sharing within the HH is widely perceived to be an extremely beneficial reform that has altered and will continue to alter relationships among community providers. However, the impacts of this reform are still emerging; since enrollment in HHs has been slow, many providers are still uncertain about the purpose and function of the HH, and many HHs are still developing consent and release documents to reliably and safely share information within the system.
4. Institutional champions were present at many of the sites that were actively implementing programs of integrated care. These individuals (as documented in other literature) tended to be senior staff with expertise in understanding and navigating the complicated MH-PC regulatory landscape within NYS and, as such, were able to lead integrated care programs in the same legislative environments in which others were not.
5. Clinics in some communities were able to create a stream of qualified and interested providers to staff their integrated care clinics through integrated care training programs

for professionals (MDs, nurses), often put in place (or spurred) by the integrated care champions.

Clinics emphasized three remaining challenges to providing PC services. First, a number of administrative barriers make the introduction of these services into MH clinics challenging. Clinic administrators described the process of obtaining proper licenses as complicated, arduous, and time-consuming, with review of several license applications taking longer than a year. Licensure issues prevented clinics from using existing infrastructure to provide care. Administrators expressed frustration over licensing requirements preventing them from integrating waiting rooms, appointment schedules, and staff, and creating integrated care spaces so that MH and PC providers can work collaboratively—for example, during shared appointments where both MH and PC staff can work with a consumer on a shared issue (e.g., smoking cessation; adherence to treatment recommendations) throughout the work day.

Second, information between providers based in the same agency or network of care remains a challenge, despite the near universal adoption of EHRs and HH information sharing systems. The main challenge reported by clinics is the proliferation of noncompatible systems, each with different access regulations and content. In smaller clinics, clinicians are still contacting outside providers by phone, receiving faxed medical records, and scanning records into local EHR systems. Some clinics have consumers from multiple HHs, each of which has its own electronic system. Few programs had truly integrated systems with a single EHR hub to facilitate integrated care.

Third, all the programs remain concerned about their ability to meet the complex social as well as medical needs of the consumers they treat. Adults with SMI often need emergency housing or help with transportation to physician appointments, without which attempts to improve quality of care and health status are unlikely to succeed. HH CM/CCs widely reported extreme limitations in housing resources in some (particularly rural) regions, and concern that they will not be able to devote sufficient time to individual consumers if their caseloads become too large following reductions in PMPM rates.

Sustainability

Concerns regarding the sustainability of MH-based PC services were heard from both PBHCI and MI clinics, but the concerns were somewhat different between the two. The PBHCI clinics in this sample were imminently facing (or had recently faced) the end of their grant periods and the consequent loss of funds to support many of the integrated care services that they provide (e.g., peers, wellness, CM/CCs). These clinics were working hard to develop alternative funding strategies, including pursuing licensure as a PC clinic and stronger partnerships with FQHCs. As the grant funding came to an end, administrators anticipated that specific services would be discontinued (wellness, peers), the quality of some services would be impacted (e.g., PC providers would need to offer shorter appointment slots, the frequency of multidisciplinary case

conferences would be reduced), but some of the changes in procedures (e.g., routine screening for PC needs) and clinic culture will remain.

MI clinics, on the other hand, were not as concerned with the sustainability of PC services. Many MI clinics had been providing basic PH screening and monitoring services prior to being able to bill for them through this mechanism, and they would likely continue to provide them if the ability to bill for them were terminated. We do not have a way to independently confirm the costs to clinics of providing PH screening and monitoring services, but administrators reported to us that the reimbursements defray but do not fully cover those costs.

Sustainability is also a major concern for HH CC/CMs. In this case the concern is that the PMPM will not cover the costs of providing care, which will require CC/CMs to take on larger caseloads and reduce the amount of time that they are able to work with the individuals they serve. This is particularly a concern for programs currently receiving "legacy rates," i.e., PMPM payments at a level that matches historical rates, which are considerably higher than standard PMPM rates. The legacy rates will soon be eliminated, and all CC/CMs will be paid at lower standard HH rates. If caseloads become too large for CC/CMs to provide care to their consumers, the main drivers of the HH program's goals of improving care and reducing costs may be compromised.

No discussion of financial sustainability of integrated care in NYS would be complete without mention of the potential forthcoming changes to how services are billed. In particular, HARPs, DSRIP, and other managed care reforms might "change everything" by bundling payments for groups of people or individuals regardless of the care they receive and creating incentives to integrating care for efficiency gains. A particular concern is the movement toward behavioral health carve-outs, which may further segregate mental health services from medical care.

On the other hand, managed care addresses only the issue of payments, and programs in that environment will still face many of the other regulatory, resource, and cultural issues raised in this report. Initiatives that aim to improve efficiencies by creating networks of care will very likely need to involve training staff, creating shared accountability within networks of care to change provider practices, and bringing interdisciplinary expertise to bear on the most complicated, high-use cases. In short, the movement to managed care may bring many of these issues to the fore because now there will be large organizations (MCOs) that have strong financial incentives to make integrated care programs work well.

Research Question 3: Innovations

Clinic staff developed a number of innovative approaches to the delivery of integrated care. These included innovations in consumer enrollment and engagement strategies, such as leveraging existing professional and social networks to identify potential consumers for Health Homes. They included innovations in work flow, such as weekly, interdisciplinary case conferences and a web-based care coordination platform allowing providers to communicate

routinely in a virtual space. Clinic staff created innovations in the structure and composition of the care team, such as leveraging the experience of peers to model healthy lifestyle changes and engagement in wellness programs, plus creating new positions to maximize staff expertise in medicine and information systems (i.e., dedicated care coordinators) that allowed case management staff to be more active in the field. Some case management groups included at least one nurse to provide input to case managers on managing consumers' primary care needs. Some clinics also restructured their care teams in accordance with the Health Home model, putting the case manager at the head of the care team. Finally, we also observed innovations in sustainability planning such as opening medical clinics to consumers' family members and caregivers in order to increase census and increase provider opportunities to bill.

Recommendations

Based on our research findings, overall, we recommend that policymakers create initiatives and/or certifications that hold mental health clinics and their partner agencies jointly accountable for core components of integrated care programs, and that accompanying licensing and funding opportunities are coordinated, approved, and ready to be implemented under all relevant New York state agencies so that clinics themselves can implement integrated services that comprehensively meet adult consumers' health care needs. The following specific recommendations are intended to meet these ends:

Recommendations to Policymakers

- *Explore state-level options that reduce administrative barriers to integrated care.* Administrators expressed frustration with the time, expense, and complexity of obtaining licenses (e.g., full DOH Article 28, integrated, co- or dual license) to provide primary medical services in their mental health clinics. Given that, policymakers may consider identifying and implementing policy strategies that further simplify and expedite mental health clinic licenses to provide medical services.
- *Consider different licensing options for clinics that are hospital affiliated or freestanding*. Our research showed that freestanding mental health clinics have less experience and fewer resources for implementing primary care services. That being the case, policymakers may wish to offer these clinics alternative licensing options that a) require fewer clinic structural changes than a typical primary care clinic, but b) require more investment in creating formal referral networks for primary care services that are not provided on site. Through this approach there may be some safeguards that are given up—for example, in the cases where the DOH requires a higher standard than OMH (e.g., frequency of fire drills). In many cases, however,

requirements may simply be different and modifiable to the satisfaction of both overseeing agencies (i.e., OMH, DOH, and, ideally, OASAS).

- *Consider special provisions for clinics in rural settings*. Site visits and survey data both showed that rural clinics experience many of the same, but also additional, barriers to care experienced in urban settings. Some of the unique needs described by participants in this study include additional costs to CM/CCs for greater travel between consumers' homes and services, provider shortages (particularly specialists) or shortages of providers accepting Medicaid, limited options for public transportation, and limited HIT infrastructure to facilitate communications and care coordination among providers, perhaps because clinics are more likely to be freestanding as opposed to part of a larger hospital system. Policymakers may reduce some of these barriers by further incentivizing local providers to care for mental health clinic consumers and by providing (e.g., through case management services) additional resources for transportation to and from medically necessary appointments. Where possible, NYS may consider the feasibility of connecting consumers in rural areas to specialists in urban centers through telemedicine and other evidence-based technologies.
- *Consider whether all mental health clinics are appropriate settings for on-site primary care services.* Given the scarcity of providers who are willing and able to provide primary care to adults with SMI, policymakers may wish to target integrated care resources to settings with the most potential to benefit consumers. Our research tentatively suggests that multiservice settings (e.g., PROS clinics) may show particular promise since consumers already have strong relationships with the agency and its providers, and because these clinics may be better prepared to offer complementary wellness or other services.
- As envisioned by the Excellence in Mental Health Act, *consider promoting a full "package" of services* (see Table E.1) *for adults with SMI through an Integrated Primary Care Behavioral Home.* Our research suggested that mental health clinic membership in the Health Home did not increase mental health providers' behavior towards shared accountability for ensuring consumer access to medical services., Policymakers may wish to consider creating a mechanism of shared accountability like a behavioral health home to further incentivize all providers to provide integrated care.
- *Identify and consider implementing strategies that promote joint accountability among all providers caring for, and plans covering, consumers' health care needs*. For example, such strategies would help ensure that primary care providers are jointly responsible for assuring quality for general medical, mental health, and substance abuse care, and behavioral health (mental health and substance use disorder) providers are equally responsible for those services and general medical care.

Strategies to instantiate joint accountability may be applied in training, practice, health plan contracts, performance incentives, and other mechanisms, including clinic and health system culture.

- *Routinely/Formally build in cost/sustainability assessments into evaluation of future integrated care initiatives.* Clinic administrators at all clinic types expressed concern about the sustainability of integrated care, and in some cases, concerns about sustainability made these administrators reluctant to further invest in infrastructure that would support integrated care (e.g., integrating case management records with clinics' own EHR). Consequently, policymakers may consider collecting cost and sustainability information during pilot tests of integrated care programs to facilitate decisionmaking among system and clinic staff who ultimately determine the uptake of integrated care programs.
- *Consider creating incentives for EHR businesses to create products that interface with available clinical information systems (e.g., partner PC records, case management systems, RHIOs, PSYCKES)*. Clinics reported that a major barrier to information sharing and coordinating care were the costs and burden associated with expanding the functionalities of their EHRs to include information from other available data sources. To address this, officials may need to take regulatory steps (such as those described by the Office of the National Coordinator [ONC] to create behavioral health EHRs with greater interoperability) that encourage EHR companies to facilitate this process.
- *Develop a "report card" on the integration implementation agenda to monitor progress over time.* Our research suggests a number of actionable items (e.g., streamlining licensing requirements, suggestions for technical assistance) that could help to facilitate the implementation of integrated care in New York state. Therefore, policymakers (or other groups, such as consumer advocacy groups) may wish to develop a system for tracking the implementation of these potential improvements over time and report on progress to stakeholders on a routine (e.g., biannual) basis.

Recommendations to Providers

- *Orient staff to the greater purpose of physical health screening and monitoring services, particularly at MI clinics.* Our research showed that the addition of health monitoring and health physicals to mental health clinics did little to improve consumer connections to primary care. It also showed that health monitoring and health physicals clinics did not train their staff to use these services as consumers' gateway to broader medical care. Clinics offering consumers any level of primary care may have more success improving consumer health if staff is trained on these expectations and provided with means to connect consumers (e.g., through enrollment

in the Health Home) to treatment for any identified physical health care needs. Providers should clearly understand the notion of shared accountability for outcomes across MH, PC, and SUD care and their role in maintaining that accountability.

- *Assess local PC access barrier and provide solutions.* During site visits, consumers and staff often reported consumer barriers to accessing care that were specific to the clinic setting (e.g., unreliable bus service to the area, primary care doctor not available on the same day as a well-attended group). In order to increase consumer enrollment and use of available primary care services, administrators should consider assessing local barriers to use of available primary care services and then provide evidence-based (e.g., flexible appointment scheduling, walk-ins, same-day) and other practical solutions, as appropriate.
- *Communicate directly with co-providers*. Providers reported (and literature suggests, e.g., Scharf et al., 2014) that care is better integrated when providers communicate about consumer needs on a regular basis. During our site visits, we observed that interdisciplinary case conferences might be particularly useful for planning and coordinating care for complex cases. Regularly scheduled opportunities for providers from multiple disciplines to discuss cases are expected to build trust, lines of communication, and may also sustain or stimulate new medical provider interest in serving populations of adults with SMI.
- *Relentless follow-up on referrals.* Administrators, providers, and consumers described access to specialty services as a major barrier to integrated care, and one that may be even more difficult to resolve than connecting consumers to primary medical services. To combat this, providers making consumer referrals to specialist providers should provide consumers with needed supports to attend these appointments (e.g., reminders, transportation) and ensure that consumers attend these appointments to improve consumer health and preserve clinic relationships with valuable and scarce lists of specialists accepting Medicaid and willing to serve their clientele.
- *Consider clarifying/operationalizing the roles and expectations of peer specialists and primary care case managers.* Administrators and providers in this study reported that there were few mechanisms to support peer specialists and primary care case managers. Clearer roles and expectations for peers and primary care case managers might help to stimulate consistent and reliable billing opportunities from payers and ensure that these positions are routinely staffed by individuals with the skills and qualifications needed to maximally benefit consumers.
- *Consider partnerships with Managed Care Organizations (MCOs) to implement integrated care.* Mental health clinics (particularly freestanding clinics) reported low rates of using data to manage and improve quality of care. MCOs, however, may already be collecting and analyzing data that can be fed back to clinics (particularly those without infrastructure and staff for data analysis) that may be useful for

informing practice. Data-driven improvements to care quality may be mutually beneficial to mental health clinics and MCOs.

Recommendations for Technical Assistance

- *Educate MH clinics about different models of integrated care and the accompanying available licensing options to provide integrated care.* New York state is a complex policy environment with many available resources and policies to facilitate integrated care. Clinic and agency administrators may benefit from ongoing technical assistance regarding resource availability and potential strategies for creating synergies by combining participation in complementary initiatives (e.g., Medicaid Incentive and Health Homes).
- *Provide ongoing support to MH clinics around the use of data for clinical care.* Mental health clinics reported low rates of systematic data use to inform care delivery. Since most clinics already have EHRs, clinics may be able to take advantage of technical assistance that demonstrates the utility of existing (or establishing) registry functions within their EHRs to promote clinical care and perhaps, simultaneously, satisfy initiative reporting requirements.
- *Investigate barriers to using data systems that support a population health management approach (e.g., PSYCKES, RHIOs) and offer training (or other supports as warranted) to enable use of those systems.* Study participants reported awareness of population health-promoting data systems, yet use of those systems was still low. Technical assistance providers may consider investigating barriers to the use of these systems and then facilitating access to them, as study participants using the systems were likely to report finding them useful for consumer care.
- *Consider providing templates (or lists of key components) of documents that mental health clinics can use to facilitate information sharing across providers on the care team.* Some clinic administrators reported challenges to obtaining consumer consent for information sharing, while others did not. Similarly, some clinics reported difficulties negotiating resource sharing with local primary care partner groups, while others had already resolved these issues. Technical assistance providers might offer templates for routine documents such as consent forms or memoranda of understanding to enable additional clinics to efficiently and effectively implement integrated care.
- *Consider technical assistance for integrating health care systems approaches with business strategies.* Given the extent of clinic concern about financial sustainability, clinics may benefit from technical assistance with how to make integrated care financially sustainable within existing business models.

Recommendations for Future Evaluation

- *Monitor and leverage the quality and performance of Health Homes.* Potential benefits from Health Homes were highly anticipated by administrators and providers, including enhanced capacity for information sharing and increased access to services for consumers, such as specialty medical care and housing; however, the degree to which these systems are functioning in practice remains unclear. To ensure optimal function of Health Homes, policymakers may wish to track consumer flow through essential steps in the care process (e.g., screening, diagnosis, treatment, wellness, aftercare, and follow-up) and provide feedback and incentives to networks based on quality metrics. Similar standards may be applied to case management and clinic-level functions of the Health Home.
- *Assess the degree to which Health Home agencies are participating in networks of care*. Although agencies may be administratively (i.e., "on paper") part of a Health Home, the extent to which they are adequately serving Health Home consumers and participating in the overall coordination of care for those individuals requires investigation. Indeed, a finding of this research was that many providers within Health Home agencies were unaware of the Health Home initiative overall. New network analysis techniques can help Health Homes and policymakers determine how well consumers are linked to services within networks, and how well CM/CCs are taking advantage of the scope of services available in their networks.
- *Conduct a formal analysis of the costs, benefits, and sustainability of the current Health Home PMPM.* Inasmuch as our research suggests widespread fears about whether the current PMPM is sufficient to cover the costs of quality case management services, particularly because current rates are bolstered by the substantially higher "legacy rates" that are set to expire, policymakers should closely monitor the impacts of reductions in PMPM on quality of care.
- *Explore whether changes in workforce and reimbursement policies help to improve physician participation in integrated care for adults with SMI.* Under the ACA, in 2014, Medicaid fees are now increased to levels that are at least equal to Medicare fees. The idea behind the fee increase is to stimulate physician participation in Medicaid and to support physicians who already participate and who could expand their Medicaid service. Whether these fee increases are sufficient to stimulate physician participation in integrated care programs (where attracting qualified physicians is often problematic) is unknown.

Conclusion

New York state's mental health clinics are implementing a range of integrated primary medical services for their adult consumers with SMI with support from a range of initiatives. These initiatives provide varying levels of financial and technical support to clinics and staff, and these different levels of investment are reflected in the scope and intensity of services that are made available to consumers, plus the extent of work flow and culture change occurring within clinics. In order to streamline the adoption of effective yet efficient approaches to integration in the state, we recommend that policymakers sponsor initiatives that include packages of core components of integrated care programs that hold mental health clinics and their partner agencies jointly accountable for those services, and that accompanying licensing and funding opportunities are coordinated, approved, and ready to be implemented under all relevant state agencies so that clinics themselves can implement integrated services that comprehensively meet adult consumers' health care needs. Providers may improve consumer access to care through strategies that promote a culture of integration by ensuring that all providers know the purpose and potential benefit of basic screening and monitoring services, searching for and implementing solutions to local barriers to care, relentless follow-up to referral appointments, and partnerships with MCOs to take advantage of available data describing the quality of care. Technical assistance on licensing, use of data and information sharing, and business models for integration may help further clinic progress. Finally, monitoring the function of ongoing initiatives, their key drivers (e.g., networks of providers and agencies), and costs will be informative for future policy decisions about which programs to scale back, maintain, or expand.

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APPENDIX

Appendix A: Standard Framework for Levels of Integrated Health Care

Table A.1. Standard Framework for Levels of Integrated Health Care

Integration Categories	Integration Levels	Description
Coordinated care	**Level 1**—Minimal collaboration	BH and PC providers work at separate facilities and have separate systems. Providers communicate rarely about cases. When communication occurs, it is usually based on a particular provider's need for specific information about a mutual consumer.
	Level 2—Basic collaboration at a distance	BH and PC providers maintain separate facilities and separate systems. Providers view each other as resources and communicate periodically about shared consumers. These communications are typically driven by specific issues. For example, a PC physician may request a copy of a psychiatric evaluation to know if there is a confirmed psychiatric diagnosis. BH is most often viewed as specialty care.
Colocated care	**Level 3**—Basic collaboration on site	BH and PC providers are colocated in the same facility but may or may not share the same practice space. Providers still use separate systems, but communication becomes more regular due to proximity, especially by phone or email, with an occasional meeting to discuss shared consumers. Movement of consumers between practices is most often through a referral process that has a higher likelihood of success because the practices are in the same location. Providers may feel like they are part of a larger team, but the team and how it operates are not clearly defined, leaving most decisions about consumer care to be made independently by individual providers.
	Level 4—Close collaboration with some system integration	There is closer collaboration between PC and BH providers due to colocation in the same practice space, and there is the beginning of integration through some shared systems. A typical model may involve a PC setting embedding a BH provider. In an embedded practice, the PC front desk schedules all appointments, and the BH provider has access and enters notes in the medical record. Often, complex consumers with multiple health care issues drive the need for consultation, which is done through personal communication. As professionals have more opportunity to share consumers, they have a better basic understanding of each other's roles.
Integrated care	**Level 5**—Close collaboration approaching an integrated practice	There are high levels of collaboration and integration between BH and PC providers. The providers begin to function as a true team, with frequent personal communication. The team actively seeks system solutions, as it recognizes barriers to care integration for a broader range of consumers. However, some issues, like the availability of an integrated medical record, may not be readily resolved. Providers understand the different roles team members need to play, and they have started to change their practice and the structure of care to achieve consumer goals.
	Level 6—Full collaboration in a Transformed/merged practice	The highest level of integration involves the greatest amount of practice change. Fuller collaboration between providers has allowed antecedent system cultures (whether from two separate systems or from one evolving system) to blur into a single transformed or merged

	practice. Providers and consumers view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all consumers, not just targeted groups.

SOURCE: CIHS, 2013.

Appendix B: Brief Summary of Forthcoming Federal and State Initiatives Impacting Integrated Care

At the federal level, initiatives include the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which requires group health plans and health insurance requirements (e.g., co-pays, deductibles) and treatment limitations (e.g., visit limits) applicable to mental health and SUDs be no more restrictive than those applied to medical benefits. MHPAEA broadly took effect in 2014 and, by removing restrictions on billable services, could provide MH clinics opportunities to bill for MH components of integrated services. On the other hand, these conditions do not extend to Medicaid and Medicare, which provide the bulk of services for adults with SMI. The effects of MHPAEA overall, and in NYS specifically, require empirical study.

Also at the federal level, movement towards Accountable Care Organizations (ACOs) could also affect the delivery of MH-based integrated care. ACOs are local groups of doctors, hospitals, and other health care providers who come together voluntarily in order to collaborate and coordinate care of the Medicare patients they serve. Different incentives and strategies within the multiple Medicaid ACO programs under development could impact provider willingness to participate and the strategies that they adopt to coordinate and integrate care (see innovation.cms.gov for additional details about Medicaid ACOs).

Within NYS, initiatives include a broad MH transition to managed care, also known as Health and Recovery Plans (HARPs). Under this plan, MH services for adults with significant needs will be managed only by plans that meet rigorous standards, such as capacity to be accountable for both in-plan and out-of-plan benefits such as housing and channels for interfacing with local government units and state psychiatric centers. Specifically, HARPs are specialized, integrated managed care products for individuals with significant MH needs that include specialized administration and management features, such as enhanced care coordination and integrated MH and PC services. Premiums will also cover pharmacy, long-term care, and HH services.

The Delivery System Reform Incentive Program (DSRIP) is a component of the New York state Medicaid Redesign Team (MRT) Waiver Amendment that seeks to achieve the goals of transforming the health care safety net, improving health care quality, improving population health, reducing avoidable hospital use, and lowering health care costs. DSRIP is designed to achieve these goals through collaborations of health care providers called Performing Provider Systems (PPS) that intend to create integrated systems to coordinate and provide care across the spectrum of settings to promote health while containing costs.

NYS is also currently preparing an application to the Center for Medicare and Medicaid Innovation (CMMI) for a State Innovation Models (SIM) grant. The SIM is an initiative by which CMMI is funding efforts by states to take promising innovations in health care delivery,

and implement strategies—including providing technical assistance and generating a wider base of multi-payer support for such efforts—to spread those innovations more broadly, statewide. NYS was awarded a $1 million Model Pre-Testing Assistance Award, to support a six-month planning process, running from April 1, 2013 through September 30, 2013, to refine and further develop that proposal. The initial roster of new care models under consideration for inclusion in the revised SIM proposal includes (1) the Patient-Centered Medical Home; (2) integration of mental health services into primary care, using the Collaborative Care model; and (3) initiatives to improve the quality and safety of hospital to home transitions—all of which have implications for the initiatives examined in this report.

Relatedly, NYS' Patient-Centered Medical Home (PCMH) program is already under way. The PCMH includes seven principles for providing comprehensive care that facilitates partnerships between individual patients and their personal physicians (PCPCC, 2007; Croghan and Brown, 2010). These principles are (1) personal physician, (2) physician-directed medical practice, (3) whole-person orientation, (4) coordinated and/or integrated care across the health system, (5) quality and safety, (6) enhanced access to care, and (7) appropriate payment structure. The National Committee for Quality Assurance (NCQA) has now published standards and guidelines for a PCMH certification process (NCQA, 2011a, 2011b), and through this process there is the opportunity to increase consistency of care across PCMHs. As of April 2013, 43 states (including NYS) have adopted a policy to advance medical homes (National Academy for State Health Policy, 2013) and a large Medicare demonstration project is currently under way (Bao, Casalino, and Pincus, 2013). Details about NYS' PCMH plan are available (NYSDH, 2013).

Finally, NYS is working towards creating an integrated (or co-licensing) system that would allow a host clinic (either an OMH, DOH, or OASAS clinic) to add additional licenses to expand its scope of service. The initiative is intended for providers who are currently authorized to operate distinct clinic programs by at least two of the participating state agencies. This mechanism is also intended for single-agency providers with two separately licensed clinics that operate in the same physical location so that they can provide integrated care more effectively. A strength of this licensing system is that providers will be allowed to use a single, integrated record.

Appendix C: Distribution of Program Survey Respondents

Table A.3. Distribution of Program Survey Respondents

	Respondents n(%)	Nonrespondents n(%)
By program type		
PBHCI	5(63)	3(37)
MI	10(20)	40(80)
sample 1	8(32)	17(68)
sample 2	2(8)	23(94)
Non-MI	7(14)	43(86)
sample 1	6(24)	19(76)
sample 2	1(4)	24(96)
By region		
Central New York	2(10)	18(90)
sample 1	2(20)	8(80)
sample 2	0(0)	10(100)
Hudson	0(0)	20(100)
sample 1	0(0)	10(100)
sample 2	0(0)	10(100)
Long Island	5(25)	15(75)
sample 1	4(40)	6(60)
sample 2	1(10)	(990)
New York City	10(36)	18(64)
sample 1 (excluding PBHCI)	5(50)	5(50)
sample 2	0(0)	10(100)
Western New York	5(25)	15(75)
sample 1	3(30)	7(70)
sample 2	2(20)	8(80)

NOTE: Rates of MI respondents are different in this table than in the text because although our records indicated that these clinics had MI licenses, five of them did not indicate in the survey that they had the MI licenses and, therefore, did not answer questions about those services.

Appendix D: New York State Integrated Physical and Behavioral Health Care Provider Survey

Welcome to the New York State Integrated Physical and Behavioral Health Care Provider Survey!

This survey is part of a research project funded by the New York State Health Foundation and conducted by the RAND Corporation, a non-profit non-partisan research organization (www.rand.org). **The focus of the project is the integration of physical health care services in behavioral health care (i.e., mental health and substance abuse treatment) settings for adults with serious mental illness (SMI).**

You are being asked to complete this survey because you have been identified by your agency as an individual who works in a behavioral health clinic that provides or coordinates physical health services for adults with SMI. This survey includes questions about your role in your clinic's efforts to provide and coordinate physical health services for behavioral health consumers, the clinic's care delivery systems, and your perceptions of clinic successes and challenges. The survey should take about 20 minutes to complete.

Survey responses will be kept **confidential**. Your clinic leadership will know whether or not you completed the survey; however, your individual responses will never be shared with your clinic or anyone outside of our RAND research team. Research reports will only include aggregated data (e.g., 50% of mental health providers completed the survey). Neither individuals nor agencies will be identifiable in published reports.

Until you submit your survey on the final page, you may exit and return to the survey at any time and your answers will be saved.

Thank you in advance for taking time from your busy schedule to respond to our survey. Your responses provide valuable information that we cannot gain from other sources.

Definitions used in this survey [please read carefully]:

Adult consumers with serious mental illness (SMI): Adults 18 years or older who receive behavioral health services and have a diagnosis of schizophrenia, other psychotic disorder, bipolar disorder, or major depression.

Main clinic: The main site licensed by the Office of Mental Health to provide outpatient behavioral

health care. Though your agency may have satellite locations under the same license, please answer the questions below with respect to the main clinic only.

Physical health services: Medical and preventive services provided for behavioral health consumers that are not traditionally provided in behavioral health settings--for example: physical exams, exercise classes, monitoring of chronic physical illnesses (e.g., diabetes), or treatment of an acute medical condition such as an ear infections or sore throat. These services may be provided on-site at the behavioral health clinic, coordinated by a case manager or care coordinator, or provided by a partner agency through a formal memorandum of understanding or contract.

1. Which of the following best describes your role at the main clinic? (Please read all of the options before choosing.)

- ◯ **Primary Care Provider** (e.g., physician, non-psychiatric nurse practitioner, physician assistant, nurse)
- ◯ **Behavioral Health Provider** (e.g., psychiatrist, psychiatric nurse practitioner, psychologist, therapist, counselor)
- ◯ **Care Coordinator** (e.g., case manager, nurse or non-nurse care manager)

2. Which of the following best describes your role as a Primary Care Provider at the main clinic?
(Check all that apply.)

- [ ] Physician
- [ ] Nurse practitioner
- [ ] Physician assistant
- [ ] Registered nurse
- [ ] Medical assistant
- [ ] Other (please specify)

3. Please describe your experiences communicating/collaborating with other staff at your main clinic who provide or coordinate physical health services for <u>adult consumers with SMI</u>.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
I communicate regularly with **behavioral health providers** to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I communicate regularly with **care managers or coordinators** to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **behavioral health providers** to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **care managers or coordinators** to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯

4. (Consider the last 6 months.) On average, how often did you attend unscheduled meetings to discuss care for specific consumers with at least one behavioral health provider?
(Include meetings that occurred in person or by phone as needed, but were not scheduled in advance. Choose the closest answer.)

- ◯ Once a week, or more often
- ◯ Once every 2 weeks
- ◯ Once a month
- ◯ Less than once a month
- ◯ Never; I did not attend such unscheduled meetings over the past 6 months

5. (Consider the last 6 months.) On average, how often did you attend scheduled meetings to discuss care for specific consumers with at least one behavioral health provider?
(Do not include unplanned calls or meetings that occurred, but were not scheduled in advance. Do include meetings that occurred in person or by phone. Choose the closest answer.)

- ◯ Once a week, or more often
- ◯ Once every 2 weeks
- ◯ Once a month
- ◯ Less than once a month
- ◯ Never; I did not attend such scheduled meetings over the past 6 months

6. Which of the following best describes your role as a Behavioral Health Provider at the main clinic?
(Check all that apply.)

- [ ] Psychiatrist
- [ ] Psychiatric nurse practitioner
- [ ] Psychologist
- [ ] Therapist
- [ ] Other (please specify)

7. Please describe your experiences communicating/collaborating with other staff at your main clinic who provide or coordinate physical health services for adult consumers with SMI.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
I communicate regularly with **primary care providers** to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I communicate regularly with **care managers or coordinators** to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **primary care providers** to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **care managers or coordinators** to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯

8. (Consider the last 6 months.) On average, how often did you attend unscheduled meetings to discuss care for specific consumers with at least one primary care provider? (Include meetings that occurred in person or by phone as needed, but were not scheduled in advance. Choose the closest answer.)

- ◯ Once a week, or more often
- ◯ Once every 2 weeks
- ◯ Once a month
- ◯ Less than once a month
- ◯ Never; I did not attend such unscheduled meetings over the past 6 months

9. (Consider the last 6 months.) On average, how often did you attend scheduled meetings to discuss care for specific consumers with at least one primary care provider? (Do not include unplanned calls or meetings that occurred, but were not scheduled in advance. Do include meetings that occurred in person or by phone. Choose the closest answer.)

- ◯ Once a week, or more often
- ◯ Once every 2 weeks
- ◯ Once a month
- ◯ Less than once a month
- ◯ Never; I did not attend such scheduled meetings over the past 6 months

10. Which of the following best describes your role as a Care Coordinator at the main clinic?
(Check all that apply.)

- [ ] Nurse care manager
- [ ] Non-nurse care manager
- [ ] Case manager
- [ ] Other (please specify)

11. Which of the following best describes your educational background?
(Check all that apply.)

- [ ] High school, no college
- [ ] Some college, no degree or certification
- [ ] Associate's degree or other post-secondary certification
- [ ] Bachelor degree
- [ ] Masters degree
- [ ] MD, PhD, or PsyD
- [ ] Other (please specify)

12. Are you an employee of a behavioral health clinic, case/care management agency, or other type of organization?

- ◯ Behavioral health clinic (i.e., mental health or substance abuse treatment clinic)
- ◯ Case/care management agency
- ◯ Other (please specify)

13. Are you a specialist in any of the following areas?
(Check all that apply.)

- [ ] No, I am not a specialist
- [ ] HIV/AIDS
- [ ] Substance use disorder
- [ ] Other specialty (please specify)

14. Which of the following tasks are part of your responsibilities at the main clinic? (Check all that apply.)

- [ ] **Assessing and monitoring** consumer physical health needs, barriers, and progress
- [ ] Developing **treatment plans**
- [ ] Educating consumers and/or family members about **physical health** conditions/treatment
- [ ] Educating consumers and/or family members about **behavioral health** conditions/treatment
- [ ] Facilitating **communication** between behavioral health providers and primary care providers
- [ ] Helping consumers access **primary care and specialist** services
- [ ] Helping consumers access **social support** services (e.g., housing, employment)
- [ ] Helping consumer enroll for **health benefits**
- [ ] Managing **referrals** to specialists
- [ ] Managing information about consumer **hospitalizations**
- [ ] Providing brief structured **psychotherapy**
- [ ] Supporting **consumers to adhere** to treatment plans
- [ ] Supporting **clinicians to comply** with medication guidelines
- [ ] Other (please specify)

15. Do you have a caseload of consumers? If yes, how many consumers on your current caseload are adults with SMI who receive physical health services provided or coordinated by your main clinic?

- ◯ No, I don't have a caseload
- ◯ Yes (specify/estimate number of adult consumers with SMI on current caseload)

16. Please describe your experiences communicating/collaborating with other staff at your main clinic who provide or coordinate physical health services for adult consumers with SMI.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
I communicate regularly with **behavioral health providers** to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I communicate regularly with **primary care providers** to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **behavioral health providers** to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **primary care providers** to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯
Behavioral health providers respect me	◯	◯	◯	◯	◯	◯
Primary care providers respect me	◯	◯	◯	◯	◯	◯
I am comfortable sharing my opinions about consumer care with **behavioral health** providers	◯	◯	◯	◯	◯	◯
I am comfortable sharing my opinions about consumer care with **primary care** providers	◯	◯	◯	◯	◯	◯

17. (Consider the last 6 months.) On average, how often did you attend unscheduled meetings to discuss care for specific consumers with at least one primary care provider and one behavioral health provider?
(Include meetings that occurred in person or by phone as needed, but were not scheduled in advance. Choose the closest answer.)

- ◯ Once a week, or more often
- ◯ Once every 2 weeks
- ◯ Once a month
- ◯ Less than once a month
- ◯ Never; I did not attend such unscheduled meetings over the past 6 months

18. (Consider the last 6 months.) On average, how often did you attend scheduled meetings to discuss care for specific consumers with at least one primary care provider and one behavioral health provider?
(Do not include unplanned calls or meetings that occurred, but were not scheduled in advance. Do include meetings that occurred in person or by phone. Choose the closest answer.)

- ◯ Once a week, or more often
- ◯ Once every 2 weeks
- ◯ Once a month
- ◯ Less than once a month
- ◯ Never; I did not attend such scheduled meetings over the past 6 months

19. Is your main clinic part of a Health Home?

- ◯ Yes
- ◯ No
- ◯ Don't know

20. Among the consumers you saw in the main clinic over the past month, what percentage were enrolled in a Health Home?
(Please give your best estimate.)

- ◯ 76% - 100%
- ◯ 51% - 75%
- ◯ 26% - 50%
- ◯ 1% - 25%
- ◯ None
- ◯ Don't know, and am unable to estimate

21. Please indicate how much you agree or disagree with the following statements about your clinic's participation in the Health Homes program. (Part 1 of 2)

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
My consumers have better access to **primary care services** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My consumers have better access to services from **medical specialists** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My consumers have better access **social services** (e.g., employment or housing support) as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
I am able to easily **share** our clinic's consumer treatment information with Health Home providers **outside** of our clinic	◯	◯	◯	◯	◯	◯
I am able to easily **access** consumer treatment information from Health Home providers **outside** of our clinic	◯	◯	◯	◯	◯	◯

22. Please indicate how much you agree or disagree with the following statements about your clinic's participation in the Health Homes program. (Part 2 of 2)

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
My consumers are more likely to have better **physical health outcomes** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My consumers are more likely to have better **behavioral health outcomes** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My **caseload** has increased as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My **administrative burden** (e.g., need to complete forms) has increased as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My **work responsibilities** related to providing or coordinating physical health care for consumers have increased as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
I received **training** that was sufficient to prepare me for my work responsibilities related to Health Homes	◯	◯	◯	◯	◯	◯

23. Please describe your experiences communicating/collaborating with other Health Home providers to provide or coordinate care for your consumers who are enrolled in a Health Home.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
I communicate regularly with **behavioral health providers** in the Health Home to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I communicate regularly with **care managers or coordinators** in the Health Home to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **behavioral health providers** in the Health Home to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **care managers or coordinators** in the Health Home to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯

24. Is your main clinic part of a Health Home?

- ◯ Yes
- ◯ No
- ◯ Don't know

25. Among the consumers you saw in the main clinic over the past month, what percentage were enrolled in a Health Home?
(Please give your best estimate.)

- ◯ 76% - 100%
- ◯ 51% - 75%
- ◯ 26% - 50%
- ◯ 1% - 25%
- ◯ None
- ◯ Don't know, and am unable to estimate

26. Please indicate how much you agree or disagree with the following statements about your clinic's participation in the Health Homes program. (Part 1 of 2)

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
My consumers have better access to **primary care services** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My consumers have better access to services from **medical specialists** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My consumers have better access **social services** (e.g., employment or housing support) as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
I am able to easily **share** our clinic's consumer treatment information with Health Home providers **outside** of our clinic	◯	◯	◯	◯	◯	◯
I am able to easily **access** consumer treatment information from Health Home providers **outside** of our clinic	◯	◯	◯	◯	◯	◯

27. Please indicate how much you agree or disagree with the following statements about your clinic's participation in the Health Homes program. (Part 2 of 2)

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
My consumers are more likely to have better **physical health outcomes** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My consumers are more likely to have better **behavioral health outcomes** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My **caseload** has increased as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My **administrative burden** (e.g., need to complete forms) has increased as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My **work responsibilities** related to providing or coordinating physical health care for consumers have increased as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
I received **training** that was sufficient to prepare me for my work responsibilities related to Health Homes	◯	◯	◯	◯	◯	◯

28. Please describe your experiences communicating/collaborating with other Health Home providers to provide or coordinate care for your consumers who are enrolled in a Health Home.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
I communicate regularly with **primary care providers** in the Health Home to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I communicate regularly with **care managers or coordinators** in the Health Home to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **primary care providers** in the Health Home to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **care managers or coordinators** in the Health Home to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯

29. Is your main clinic part of a Health Home?

- ◯ Yes
- ◯ No
- ◯ Don't know

30. Among the consumers you saw in the main clinic over the past month, what percentage were enrolled in a Health Home?
(Please give your best estimate.)

- ◯ 76% - 100%
- ◯ 51% - 75%
- ◯ 26% - 50%
- ◯ 1% - 25%
- ◯ None
- ◯ Don't know, and am unable to estimate

31. Please indicate how much you agree or disagree with the following statements about your clinic's participation in the Health Homes program. (Part 1 of 2)

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
My consumers have better access to **primary care services** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My consumers have better access to services from **medical specialists** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My consumers have better access **social services** (e.g., employment or housing support) as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
I am able to easily **share** our clinic's consumer treatment information with Health Home providers **outside** of our clinic	◯	◯	◯	◯	◯	◯
I am able to easily **access** consumer treatment information from Health Home providers **outside** of our clinic	◯	◯	◯	◯	◯	◯

32. Please indicate how much you agree or disagree with the following statements about your clinic's participation in the Health Homes program. (Part 2 of 2)

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
My consumers are more likely to have better **physical health outcomes** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My consumers are more likely to have better **behavioral health outcomes** as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My **caseload** has increased as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My **administrative burden** (e.g., need to complete forms) has increased as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
My **work responsibilities** related to providing or coordinating physical health care for consumers have increased as a result of my clinic's participation in Health Homes	◯	◯	◯	◯	◯	◯
I received **training** that was sufficient to prepare me for my work responsibilities related to Health Homes	◯	◯	◯	◯	◯	◯

33. Please describe your experiences communicating/collaborating with other Health Home providers to provide or coordinate care for your consumers who are enrolled in a Health Home.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
I communicate regularly with **behavioral health providers** in the Health Home to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I communicate regularly with **primary care providers** in the Health Home to share clinically-relevant information about my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **behavioral health providers** in the Health Home to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯
I collaborate closely with **primary care providers** in the Health Home to develop treatment plans for my consumers	◯	◯	◯	◯	◯	◯

34. In your opinion, what are the main benefits of your clinic's participation in the Health Homes program?

◯ Don't know

◯ Main benefits (please specify)

35. Below is a list of potential challenges to providing or coordinating physical health services in a behavioral health clinic related to Health Homes. Please rate the severity of each challenge.

	Not a challenge	Minor challenge	Major challenge	Don't know
Connecting consumers to **primary care** services through the Health Home	◯	◯	◯	◯
Connecting consumers to **specialty medical care** services through the Health Home	◯	◯	◯	◯
Connecting consumers to **social** services (e.g., housing, employment) through the Health Home	◯	◯	◯	◯
Contacting **referrals** from the state (i.e., top-down referrals)	◯	◯	◯	◯
Enrolling eligible consumers into the Health Home	◯	◯	◯	◯
Finding **providers** within the Health Home who understand the needs of the consumers with SMI and treat them with respect	◯	◯	◯	◯
Meeting **data** collection and reporting requirements of Health Homes	◯	◯	◯	◯
Obtaining **consent** from consumers for health information sharing	◯	◯	◯	◯
Sharing consumer health information with providers **outside** of our clinic	◯	◯	◯	◯

Other challenges (please specify)

36. In your opinion, how could the Health Homes program (or your clinic's involvement in the program) be improved?

◯ Don't know

◯ Suggested improvements (please specify)

New York State Office of Mental Health allows some behavioral health clinics to provide on-site health physicals (e.g., physical exams) **and/or health monitoring** (e.g., to assess blood pressure, body mass index, smoking status) **and bill Medicaid for these services.**

37. Does your main clinic bill Medicaid for providing health physicals and/or health monitoring on-site (i.e., at your behavioral health clinic location)?

- ◯ Yes
- ◯ No
- ◯ Don't know

38. Among the consumers you saw in the main clinic over the past month, what percentage had received health physicals and/or monitoring services <u>in the past month</u> that were billable to Medicaid?
(Please give your best estimate.)

- ◯ 76% - 100%
- ◯ 51% - 75%
- ◯ 26% - 50%
- ◯ 1% - 25%
- ◯ None
- ◯ Don't know, and am unable to estimate

39. Please indicate how much you agree or disagree with the following statements about your main clinic's ability to bill Medicaid for providing on-site health physicals (e.g., physical health exams) and/or health monitoring (e.g., to assess blood pressure, body mass index, smoking status). (Part 1 of 2)

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
My consumers have better access to **primary care services** as a result of our clinic's provision of on-site health physicals and/or health monitoring	◯	◯	◯	◯	◯	◯
My consumers have better access to services from **medical specialists** as a result of our clinic's provision of on-site health physicals and/or health monitoring	◯	◯	◯	◯	◯	◯
My consumers are more likely to have better **physical health** outcomes as a result of our clinic's provision of on-site health physicals and/or health monitoring	◯	◯	◯	◯	◯	◯
My consumers are more likely to have better **behavioral health** outcomes as a result of our clinic's provision of on-site health physicals and/or health monitoring	◯	◯	◯	◯	◯	◯

40. Please indicate how much you agree or disagree with the following statements about your main clinic's ability to bill Medicaid for providing on-site health physicals (e.g., physical health exams) and/or health monitoring (e.g., to assess blood pressure, body mass index, smoking status). (Part 2 of 2)

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
My **caseload** has increased as a result of our clinic's provision of on-site health physicals and/or health monitoring	◯	◯	◯	◯	◯	◯
My **administrative burden** (e.g., need to complete forms) has increased as a result of our clinic's provision of on-site health physicals and/or health monitoring	◯	◯	◯	◯	◯	◯
My **work responsibilities** related to providing or coordinating physical health services have increased as a result of our clinic's provision of on-site health physicals and/or health monitoring	◯	◯	◯	◯	◯	◯
I received **training** that was sufficient to prepare me for my work responsibilities related to our clinic's provision of on-site health physicals and/or health monitoring	◯	◯	◯	◯	◯	◯

41. In your opinion, what are the main benefits of your clinic's ability to bill Medicaid for providing on-site health physicals and/or health monitoring?

◯ Don't know

◯ Main benefits (please specify)

42. Below is a list of potential challenges to behavioral health clinics related to billing Medicaid for on-site health physicals or health monitoring. Please rate the severity of each challenge.

	Not a challenge	Minor challenge	Major challenge	Don't know
Connecting consumers to **primary care services** when indicated by their health physicals or monitoring results	◯	◯	◯	◯
Connecting consumers to **specialty medical care** when indicated by their health physicals or monitoring results	◯	◯	◯	◯
Hiring qualified staff to provide on-site health physicals or monitoring	◯	◯	◯	◯
Maintaining **sufficient volume** of consumers to sustain staff required to provide health physicals or monitoring	◯	◯	◯	◯
Scheduling consumers for health physicals or monitoring in our clinic	◯	◯	◯	◯
Sharing consumer health information with providers **within** our clinic	◯	◯	◯	◯
Sharing consumer health information with providers **outside** of our clinic	◯	◯	◯	◯

Other challenges (please specify)

43. In your opinion, how could your clinic's ability to bill Medicaid for providing on-site health physicals and/or health monitoring be improved?

- ◯ Don't know
- ◯ Suggested improvements (please specify)

44. Has your main clinic received a PBHCI grant to provide or coordinate physical health services for behavioral health consumers?
(PBHCI stands for Primary and Behavioral Health Care Integration and the grant is administered by the Substance Abuse and Mental Health Services Administration, SAMHSA.)

- ◯ Yes
- ◯ No
- ◯ Don't know

45. Which of the following PBHCI grant-funded services are used by <u>your consumers at the main clinic</u>?

(Check all that apply.)

- [ ] Primary medical care services
- [ ] Case management
- [ ] Wellness services (e.g., exercise classes, diabetes education)
- [ ] None, my consumers do not use services funded by PBHCI
- [ ] Don't know
- [ ] Other PBHCI-funded services (please specify)

46. (Part 1 of 2) Please indicate how much you agree or disagree with the following statements about your clinic's use of the PBHCI grant.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
My consumers have better access to **primary care services** as a result of my clinic receiving a PBHCI grant	◯	◯	◯	◯	◯	◯
My consumers have better access to services from **medical specialists** as a result of my clinic receiving a PBHCI grant	◯	◯	◯	◯	◯	◯
My consumers have better access to **social services** (e.g., employment or housing support) as a result of my clinic receiving a PBHCI grant	◯	◯	◯	◯	◯	◯
I am able to easily **share** our clinic's consumer treatment information with providers **outside** of our clinic	◯	◯	◯	◯	◯	◯
I am able to easily **access** consumer treatment information from providers **outside** of our clinic	◯	◯	◯	◯	◯	◯

47. (Part 2 of 2) Please indicate how much you agree or disagree with the following statements about your clinic’s use of the PBHCI grant.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know / Not applicable
My consumers are more likely to have better **physical health outcomes** as a result of my clinic receiving a PBHCI grant	◯	◯	◯	◯	◯	◯
My consumers are more likely to have better **behavioral health outcomes** as a result of my clinic receiving a PBHCI grant	◯	◯	◯	◯	◯	◯
My **caseload** has increased as a result of my clinic receiving a PBHCI grant	◯	◯	◯	◯	◯	◯
My **administrative burden** (e.g., need to complete forms) has increased as a result of my clinic receiving a PBHCI grant	◯	◯	◯	◯	◯	◯
My **work responsibilities** related to providing or coordinating physical health care for consumers have increased as a result of my clinic receiving a PBHCI grant	◯	◯	◯	◯	◯	◯
I received **training** that was sufficient to prepare me for my work responsibilities related to my clinic receiving a PBHCI grant	◯	◯	◯	◯	◯	◯

48. In your opinion, what are the main benefits of your clinic's participation in the PBHCI grant program?

◯ Don't know

◯ Main benefits (please specify)

49. Below is a list of common challenges to providing or coordinating physical health services in behavioral health clinics related to PBHCI. Please rate the severity of each challenge.

	Not a challenge	Minor challenge	Major challenge	Don't know
Connecting consumers to PBHCI-supported **primary care services**	◯	◯	◯	◯
Connecting consumers to PBHCI-supported **specialty medical care**	◯	◯	◯	◯
Connecting consumers to PBHCI-supported **social services** (e.g., employment or housing support)	◯	◯	◯	◯
Enrolling consumers into our clinic's PBHCI program	◯	◯	◯	◯
Hiring qualified staff to provide PBHCI services (e.g., primary care, wellness education) at our clinic	◯	◯	◯	◯
Sharing consumer health information with providers **within** our clinic	◯	◯	◯	◯
Sharing consumer health information with providers **outside** of our clinic	◯	◯	◯	◯

Other challenges (please specify)

50. In your opinion, how could the PBHCI grant program (or your clinic's participation in the program) be improved?

◯ Don't know

◯ Suggested improvements (please specify)

51. Which of the following consumer health records can you access for adult consumers with SMI who receive physical health services provided or coordinated by your main clinic?

- [ ] Mental health
- [ ] Substance abuse treatment
- [ ] Primary care
- [ ] Other (please specify)

52. Which of the following consumer health records can you contribute to or change for adult consumers with SMI who receive physical health services provided or coordinated by your main clinic?

- [ ] Mental health
- [ ] Substance abuse treatment
- [ ] Primary care
- [ ] Other (please specify)

53. What source(s) of information do you use to determine whether an adult consumer with SMI who receives physical health services provided or coordinated by your main clinic has been hospitalized?
(Check all that apply.)

- [ ] Electronic health records
- [ ] Health Home database
- [ ] Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) database
- [ ] Regional Health Information Organization (RHIO) database
- [ ] Besides asking a consumer directly I have no other means of determining whether the consumer has been hospitalized
- [ ] Other (please specify)

54. Do you receive productivity or performance reports about your work in the main clinic? If yes, what type of reports do you receive? (Check all that apply.)

- [ ] Personalized productivity reports (e.g., number of hours you billed)
- [ ] Personalized performance reports (e.g., number of appropriate physical health screenings you provided)
- [ ] Program performance reports (e.g., weight or smoking status of consumers over time)
- [ ] No, I don't receive productivity or performance reports
- [ ] Other (please specify)

55. Overall, thinking about your work with behavioral health providers and primary care providers to provide and coordinate physical health services for behavioral health consumers at your main clinic, please indicate how much you agree or disagree with the following statements.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
Behavioral health providers and primary care providers **trust** each other.	◯	◯	◯	◯	◯	◯
Behavioral health providers and primary care providers **respect** each other.	◯	◯	◯	◯	◯	◯
Behavioral health providers and primary care providers **work comfortably** together.	◯	◯	◯	◯	◯	◯
Behavioral health providers and primary care providers have **regular, positive interactions** in our clinic.	◯	◯	◯	◯	◯	◯
Behavioral health providers and primary care providers approach consumer care with a sense of **partnership** and **shared decision-making**.	◯	◯	◯	◯	◯	◯
Our clinic leadership **values** integrated physical and behavioral health care	◯	◯	◯	◯	◯	◯
Our clinic leadership is **effective** at promoting integrated physical and behavioral health care	◯	◯	◯	◯	◯	◯
Overall, I am **satisfied** with my job	◯	◯	◯	◯	◯	◯

56. To what degree does your main clinic do each of the following for adult consumers with SMI?

	Not at all	Partially	Largely	Fully	Don't know
Care management and coordination of physical and behavioral health services	◯	◯	◯	◯	◯
Clinic has a **culture** of treating the "whole person"	◯	◯	◯	◯	◯
Screening for physical health conditions and risk factors	◯	◯	◯	◯	◯
Providing other **preventive** services (e.g., immunizations)	◯	◯	◯	◯	◯
Referrals to external health providers, including specialists	◯	◯	◯	◯	◯
Sharing consumer health data among primary care and behavioral health providers **within** our clinic	◯	◯	◯	◯	◯
Sharing consumer **health data** with providers/facilities **outside** our clinic	◯	◯	◯	◯	◯
Sharing consumer **health data** with **consumers** (e.g., to motivate behavior change)	◯	◯	◯	◯	◯
Tracking consumer health information over time (e.g., by registry)	◯	◯	◯	◯	◯
Wellness services (e.g., smoking cessation, diabetes education)	◯	◯	◯	◯	◯

Other (please specify)

57. Below is a list of potential challenges to providing or coordinating physical health services in behavioral health clinics. Please identify the top 5 challenges for your main clinic and rank each from 1 to 5.
(Rank only the top 5 and leave other rows blank.)

	1 (most significant challenge)	2	3	4	5
Connecting consumers to **primary care** services	◯	◯	◯	◯	◯
Connecting consumers to **specialty medical** care	◯	◯	◯	◯	◯
Connecting consumers to **social** services	◯	◯	◯	◯	◯
Data reporting requirements / administrative burden	◯	◯	◯	◯	◯
Getting different provider types (e.g. primary care physicians and psychiatrists) to **work together** effectively	◯	◯	◯	◯	◯
Hiring or maintaining qualified staff to provide integrated care (e.g., physical health, care coordination) services	◯	◯	◯	◯	◯
Physical space for integrated care	◯	◯	◯	◯	◯
Recruiting or engaging consumers in primary care	◯	◯	◯	◯	◯
Reimbursement / **financial** sustainability	◯	◯	◯	◯	◯
Shared **decision-making** between primary care and behavioral health leadership	◯	◯	◯	◯	◯
Sharing consumer **health information** with providers **within** our clinic	◯	◯	◯	◯	◯
Sharing consumer **health information** with providers **outside** our clinic	◯	◯	◯	◯	◯
Transportation for consumers	◯	◯	◯	◯	◯
Other	◯	◯	◯	◯	◯

If you selected "Other" as a top 5 most significant challenge, please briefly describe this challenge.

58. What services do you think your consumers need that are currently too difficult to get?

- ◯ Don't know
- ◯ None
- ◯ Services needed (please specify)

59. What do you like best about your main clinic's efforts to provide or coordinate physical health services for behavioral health consumers?

- ◯ Don't know
- ◯ What I like best (please specify)

60. Before you exit the survey, is there anything else you'd like to tell us about your main clinic's efforts to provide or coordinate physical health services for behavioral health consumers? Any advice or changes that you would recommend to other providers, clinics, or policy-makers?

- ◯ No additional comments
- ◯ Additional comments (please specify)

Appendix E: New York State Integrated Physical and Behavioral Health Care Program Survey

New York State Integrated Physical and Behavioral Health Care Program Survey

This survey is part of a research project funded by the New York State Health Foundation and conducted by the RAND Corporation, a non-profit non-partisan research organization (www.rand.org). The focus of the project is the integration of physical health care services in behavioral health (i.e., mental health and substance abuse treatment) settings for adults with serious mental illness.

Survey responses will be kept **confidential** and stored separately from email addresses, agency names, and any information that could identify your agency. A separate file will link responses from this survey to responses from other providers at your agency for research purposes only. Research reports will only include aggregated data (e.g., X% of programs reported Y). Neither individuals nor agencies will be identifiable in published reports.

This survey includes questions about your integrated care program's organizational structure, services provided, staffing, care delivery systems, financing, and challenges.

No single person at your agency may have all the information asked in this survey. Please work with your team to get the most complete and accurate information available and then **submit one copy of this form** by email.

Thank you in advance for taking time from your busy schedules to respond to our survey. Your responses provide valuable information that we cannot gain from other sources.

Definitions used in this survey:

Adult consumers with serious mental illness (SMI): Adults age 18 and older who receive behavioral health services and have a diagnosis of schizophrenia, other psychotic disorder, bipolar disorder, or major depression.

Main clinic: The main site licensed by the Office of Mental Health to provide outpatient behavioral health care. Though your site may have satellite locations under the same license, please answer the questions below with respect to the main clinic only.

Physical health services: Medical and preventive services provided for behavioral health consumers that are not traditionally provided in behavioral health settings—for example: physical exams, exercise classes, monitoring of chronic physical illnesses (e.g., diabetes), or treatment of an acute medical condition such as an ear infections or sore throat. These services may be provided on-site at the behavioral health clinic, coordinated by a case manager or care coordinator, or provided by a partner agency through a formal memorandum of understanding or contract.

PROGRAM STRUCTURE

SERVICES

1. Which of the following physical health services are provided to adult consumers with SMI at your main clinic location? For each type of service provided at your main clinic, indicate the following:
    a. Location: whether service is provided in a separate space from behavioral health services (e.g., separate wing, floor, or building), or in shared spaces (e.g., waiting areas, provider workspaces)
    b. Availability: how frequently service is available at the main clinic
    c. Number of adults consumers with SMI who received the service at your main clinic over the past year (provide your best estimate)

Service *(Check if available **at your main clinic**; if not available, leave the row blank)*	**Location** Relative to behavioral health services at main clinic *(Check all that apply)*	**Availability** Number of days per week *(Enter number)*	**Availability** Check if available evenings (after 6pm) and/or weekends	**Number of SMI consumers receiving service at your main clinic over the past year** *(Estimate)*
☐**Screening** for or **monitoring** of chronic physical health conditions (e.g., diabetes) or disease indicators (e.g., blood pressure)	☐ Separate space (i.e., separate wing, floor, or building) ☐ Shared reception area ☐ Shared waiting room ☐ Connected provider workspaces		☐	
☐**Physical** exams	☐ Separate space (i.e., separate wing, floor, or building) ☐ Shared reception area ☐ Shared waiting room ☐ Connected provider workspaces		☐	
☐Treatment of **chronic** physical health conditions (e.g., diabetes)	☐ Separate space (i.e., separate wing, floor, or building) ☐ Shared reception area ☐ Shared waiting room ☐ Connected provider workspaces		☐	
☐Treatment of **acute** physical health conditions (e.g., sore throat)	☐ Separate space (i.e., separate wing, floor, or building) ☐ Shared reception area ☐ Shared waiting room ☐ Connected provider workspaces		☐	

(Physical health services provided for adults consumers with SMI at your main clinic, continued.)

Service *(Check if available **at your main clinic**; if not available, leave the row blank)*	**Location** Relative to behavioral health services at main clinic *(Check all that apply)*	**Availability** Number of days per week *(Enter number)*	**Availability** Check if available evenings (after 6pm) and/or weekends	**Number of SMI consumers receiving service at your main clinic over the past year** *(Estimate)*
☐**Dental** services	☐ Separate space (i.e., separate wing, floor, or building) ☐ Shared reception area ☐ Shared waiting room ☐ Connected provider workspaces		☐	
☐**HIV/AIDS treatment**	☐ Separate space (i.e., separate wing, floor, or building) ☐ Shared reception area ☐ Shared waiting room ☐ Connected provider workspaces		☐	
☐Medical management of **addictive disorders** (e.g., buprenorphine treatment)	☐ Separate space (i.e., separate wing, floor, or building) ☐ Shared reception area ☐ Shared waiting room ☐ Connected provider workspaces		☐	
☐**Pharmacy**	☐ Separate space (i.e., separate wing, floor, or building) ☐ Shared reception area ☐ Shared waiting room ☐ Connected provider workspaces		☐	
☐**Phlebotomy** / blood drawing	☐ Separate space (i.e., separate wing, floor, or building) ☐ Shared reception area ☐ Shared waiting room ☐ Connected provider workspaces		☐	

2. Which of the following physical health services are provided to your main clinic's adult consumers with SMI by a formal partner organization? (Note that a formal partner is a health care organization with which your behavioral health clinic has a contract or memorandum of agreement.) For each type of service provided, indicate the following:
    a. Type of partner organization providing service: e.g., FQHC, other health clinic, hospital, other type
    b. Location: closest distance in miles from main clinic that service is provided
    c. Number of your main clinic's adults consumers with SMI who received the service from a partner organization over the past year (provide your best estimate)

Service *(Check if provided by a **formal partner** organization)*	**Type of partner organization** *(Check all that apply)*	**Location** *(Enter distance of closest location to main clinic in miles)*	**Number of your main clinic's SMI consumers receiving service from partner over the past year** *(Estimate)*
☐**Screening** for or **monitoring** of chronic physical health conditions (e.g., diabetes) or disease indicators (e.g., blood pressure)	☐Federally Qualified Health Clinic (FQHC) ☐Other health clinic ☐Hospital ☐Other (specify) _____		
☐**Physical** exams	☐Federally Qualified Health Clinic (FQHC) ☐Other health clinic ☐Hospital ☐Other (specify) _____		
☐Treatment of **chronic** physical health conditions (e.g., diabetes)	☐Federally Qualified Health Clinic (FQHC) ☐Other health clinic ☐Hospital ☐Other (specify) _____		
☐Treatment of **acute** physical health conditions (e.g., sore throat)	☐Federally Qualified Health Clinic (FQHC) ☐Other health clinic ☐Hospital ☐Other (specify) _____		

(Physical health services provided for your main clinic's adults consumers with SMI by formal partner organizations, continued.)

Service *(Check if provided by a **formal partner** organization)*	**Type of partner organization** *(Check all that apply)*	**Location** *(Enter distance of closest location to main clinic in miles)*	**Number of your main clinic's SMI consumers receiving service from partner over the past year** *(Estimate)*
☐**Dental** services	☐Federally Qualified Health Clinic (FQHC) ☐Other health clinic ☐Hospital ☐Other (specify)		
☐**HIV/AIDS treatment**	☐Federally Qualified Health Clinic (FQHC) ☐Other health clinic ☐Hospital ☐Other (specify)		
☐Medical management of **addictive disorders** (e.g., buprenorphine treatment)	☐Federally Qualified Health Clinic (FQHC) ☐Other health clinic ☐Hospital ☐Other (specify)		
☐**Pharmacy**	☐Federally Qualified Health Clinic (FQHC) ☐Other health clinic ☐Hospital ☐Other (specify)		
☐**Phlebotomy** / blood drawing	☐Federally Qualified Health Clinic (FQHC) ☐Other health clinic ☐Hospital ☐Other (specify)		
☐Other services (specify)	☐Federally Qualified Health Clinic (FQHC) ☐Other health clinic ☐Hospital ☐Other (specify)		

3. Over the past year, what wellness services have been available for your adult consumers with SMI? Include services provided by your main clinic or by formal partner organizations to which you refer, in either individual or group sessions. For each service available, indicate where this service was provided. Also, enter the number of months over the past year the service was available and, during this time, the number of hours per week the service was provided.

Service *(Check if your program includes this type of Wellness service)*	**Location**		**Availability**	
	At main clinic *(Check if yes)*	At other location *(Check if yes)*	Number of months over the past year	Number of hours per week (when available)
☐ Diabetes education	☐	☐		
☐ Other chronic physical health condition education	☐	☐		
☐ Exercise	☐	☐		
☐ Nutrition education	☐	☐		
☐ Instruction on cooking healthy foods	☐	☐		
☐ Smoking cessation	☐	☐		
☐ Stress management / Relaxation training	☐	☐		
☐ Substance use disorder support	☐	☐		
☐ Other (please specify type, location, and availability)				

4. Briefly describe when your main clinic first began providing or coordinating physical health services for adult consumers with SMI, and what services were initially provided.

5. Does your main clinic have a systematic process for reducing unnecessary hospitalizations for adult consumers with SMI?

◯ Yes ◯ No

→ If yes, please briefly describe the process:

ORGANIZATION:

6. What licenses does your main clinic currently hold?
   (Check all that apply)
   - ☐ NYS Office of Mental Health (OMH)
     - ☐ Article 31
     - ☐ *Expanded license for health physicals*
     - ☐ *Expanded license for health monitoring*
     - ☐ Comprehensive Personalized Recovery Oriented Services (PROS) license
     - ☐ Limited license Personalized Recovery Oriented Services (PROS)
   - ☐ NYS Office of Alcoholism & Substance Abuse Services (OASAS)
   - ☐ NYS Department of Health (DOH) (Article 28)
   - ☐ *OMH-DOH Special dual license*
   - ☐ *OMH-DOH Co-license option*
   - ☐ Other - specify: ☐

7. Does your main clinic bill Medicaid for providing on-site health physicals (e.g., physical exams)?

   ◯ Yes ◯ No

8. Does your main clinic bill Medicaid for providing on-site health monitoring (e.g., to assess blood pressure, body mass index, smoking status)?

   ◯ Yes ◯ No

9. Is the agency that oversees your main clinic a lead Health Home agency?

   ◯ Yes ◯ No

10. Is your main clinic part of any Health Homes for which it is not the lead agency?

    ◯ Yes ◯ No

    → If yes, how many Health Homes is your main clinic part of, but not the lead agency for? ☐

11. Is the agency that oversees your main clinic part of a health system that includes a general hospital?

    ◯ Yes ◯ No

CONSUMERS

12. Over the past year, approximately how many unduplicated consumers in total (including children and adults, any diagnosis) were served by your main clinic? _____

    a. Over the past year, approximately how many unduplicated adult consumers with SMI were served by your main clinic? _____

    b. Over the past year, approximately how many unduplicated adult consumers with SMI were eligible to receive physical health services provided or coordinated by your main clinic? _____

13. Approximately how many adult consumers with SMI seen at your main clinic are currently eligible for Health Homes? _____ ☐ Don't know

14. Approximately how many adult consumers with SMI seen at your main clinic are currently enrolled in a Health Home? _____ ☐ Don't know

15. What is your best estimate for the percentage of all adult consumers with SMI seen at your main clinic over the past year with the following types of health insurance?

Insurance Status	Percentage
Medicaid only	
Medicare only	
Both Medicaid and Medicare	
Private insurance	
No insurance	

16. Does your main clinic's intake process for behavioral health consumers include a systematic assessment of any of the following physical health care preferences or needs?
    (Check all that apply.)
    - ☐ Does consumer have a primary care physician
    - ☐ If yes, does consumer feel comfortable with the primary care physician
    - ☐ Is consumer interested in receiving physical health services provided or coordinated by the main clinic?

17. Are the physical health services provided by your main clinic available to individuals who do not receive behavioral health services from your main clinic?
    (Check one.)
    - ◯ **Yes**, physical health services available to those who do not receive behavioral health care at main clinic
    - ◯ **No**, physical health services only for behavioral health consumers at main clinic

STAFFING

18. Please indicate how many full time equivalent (FTE) staff of the following types provide or coordinate physical health services for behavioral health consumers at your main clinic. Provide a total FTE value, and then also estimate the subset of total FTEs funded by grants.

Staff Types *(Check if program includes this type of staff. Do not count any individual staff members in more than one category.)*	**FTE** Total	**FTE** Subset of total that is grant-funded
Behavioral Health Providers		
☐ Psychiatrist		
☐ Psychiatric nurse practitioner		
☐ Other licensed practitioner (e.g., psychologist, licensed clinical social worker, marriage and family therapist)		
☐ Non-licensed behavioral health practitioner		
Primary Care Providers		
☐ Primary Care physician		
☐ Nurse practitioner / Physician assistant		
☐ Registered nurse / Licensed practical nurse		
Care/Case Managers/Coordinators		
☐ Nurse care coordinator *(links physical and behavioral health, and to other services)*		
☐ Non-nurse care coordinator *(links physical and behavioral health, and to other services)*		
☐ Case manager *(links to community services)*		
Other Staff		
☐ Medical Assistant		
☐ Peer specialist		
☐ Wellness specialist		
☐ Other (specify) _____		
☐ Other (specify) _____		

CARE MANAGEMENT / COORDINATION

Care management and coordination provides individualized support to help consumers navigate health and/or social service resources. Staff providing these services may have behavioral health, medical, or non-professional backgrounds, and may be referred to as case managers, care managers, or care coordinators.

19. Are care managers or coordinators who provide services for your main clinic's behavioral health consumers directly employed by your behavioral health agency, or are they employed by an external agency? *(Check all that apply)*

    ☐ Employed by our behavioral health care agency
    ☐ Employed by a specialized care management agency
    ☐ Other (specify) [ ]

20. Approximately what percentage of all adult consumers with SMI seen in your main clinic receive services from care managers or coordinators who coordinate both behavioral health and primary care services?

    ○ 76%-100% of all adult consumers with SMI
    ○ 51%-75%
    ○ 26%-50%
    ○ 1%-25%
    ○ Don't know

21. Which of the following tasks are care managers or coordinators who see adult consumers with SMI with physical health care needs (e.g., diabetes) responsible for?*(Check all that apply)*

    ☐Assessing and monitoring consumer health needs, barriers, and progress
    ☐Developing treatment plans
    ☐Educating consumers and/or family members about physical health conditions/treatment
    ☐Educating consumers and/or family members about behavioral health conditions/treatment
    ☐Helping consumers access primary care and specialist services
    ☐Helping consumers access social support services (e.g., housing, employment)
    ☐Helping consumer enroll for health benefits
    ☐Managing referrals to specialists
    ☐Managing information about consumer hospitalizations
    ☐Providing brief structured psychotherapy
    ☐Facilitating communication between behavioral and primary care providers
    ☐Supporting consumers to adhere to treatment plans
    ☐Supporting clinicians to comply with medication guidelines
    ☐Other (specify:) [ ]

INFORMATION SYSTEMS
STRUCTURE

22. Does your main clinic use an electronic health record (EHR)?
    - ◯ No, EHRs are not used
    - ◯ Yes, for both behavioral health (BH) and primary care (PC) information
    - ◯ Yes, for BH information only
    - ◯ Yes, for PC information only

    → If yes, is your program's electronic health record linked to Regional Health Information Organization (RHIO) data?

    ◯ Yes ◯ No

23. Does your main clinic use electronic records for case management or coordination data?

    ◯ Yes ◯ No

    → If yes, does your program use a separate software specifically for case management or coordination data?

    ◯ Yes ◯ No

    → If Yes, are case management data linked to your program's EHR?

    ◯ Yes ◯ No

24. Indicate which of the following types of consumer health information are integrated into a single record, and which are in separate records.

Health Information	**Integrated into single record** *(Check if yes)*	**Separate record** *(Check if yes)*
Mental health	◯	◯
Substance use treatment	◯	◯
Primary care / physical health	◯	◯
Pharmacy	◯	◯

25. Which behavioral health providers in your main clinic have access to primary care health records, including clinical visit notes? *(Check all that apply.)*

    - ☐ Case Manager
    - ☐ Psychiatrist
    - ☐ Psychiatric nurse practitioner
    - ☐ Psychologist
    - ☐ Other Therapist / Counselor (not Psychologist) _____

26. Which primary care providers in your main clinic have access to mental health records, including clinical visit notes? *(Check all that apply.)*

☐ Physician

☐ Physician assistant / Nurse practitioner

☐ Medical Assistant

☐ Registered nurse / Licensed practical nurse

☐ Other primary care provider (specify) _____

A clinical registry is a collection of clinical information (e.g., diagnoses, individual service use encounters) for a group of consumers, such as those served by integrated care programs. A clinical registry can be paper-based or electronic. Some electronic health records (EHRs) also function as clinical registries—for example, some EHRs can be used to generate lists of all consumers with a specific diagnosis.

27. Does your main clinic use a clinical registry for documenting primary care or behavioral health conditions and/or service use for individual consumers?

◯ Yes ◯ No

→ If yes, what is the format of your main clinic's clinical registry?

◯ Electronic, and integrated with EHR
◯ Electronic, but not integrated with EHR
◯ Paper-based
◯ Other (specify) _____

→ If electronic, which of the following clinical information about consumers is recorded in your electronic system as structured or searchable data?

Having structured or searchable data means that the system can generate lists of consumers who meet specific criteria, for example all those who have diabetes, or smoke tobacco. *(Check all that apply)*

☐ Allergies, including medication allergies and adverse reactions

☐ Blood pressure, with date of update

☐ Height

☐ Weight

☐ Status of tobacco use

☐ Diabetes status

☐ Hypertension status

☐ Other specific conditions or risk factors (specify)

_____

INFORMATION SYSTEMS CAPABILITIES AND USAGE

28. We are interested in how your main clinic provides and coordinates physical health care for adult consumers with SMI. For those consumers who receive physical health services provided or coordinated by your main clinic, how often does each of the following occur?

Care activity or capability	*(Check how often)* Never	Rarely	Sometimes	Always, or almost always
a) An electronic system reminds clinicians about consumer preventive care needs (e.g., immunizations, lab tests for consumers with diabetes) at the time of the consumer's visit	○	○	○	○
b) We use consumer information to generate lists and follow-up with consumers not recently seen by the program	○	○	○	○
c) Lab tests are tracked until results are available, and flagged and followed-up with if results are overdue	○	○	○	○
d) Consumer attendance at referred appointments is tracked	○	○	○	○
e) We use an electronic system to monitor medications and prevent medication interactions/incompatibility	○	○	○	○
f) To manage consumer medications, we use an electronic system that is accessible by our formal partner organizations (e.g., pharmacies or clinics with whom we have a contract or MOU/MOA)	○	○	○	○
g) To manage consumer medications, we use an electronic system that is accessible by other non-partner organizations (e.g., pharmacies, health clinics)	○	○	○	○
h) We obtain consumer care summaries from hospitals or other external facilities	○	○	○	○
i) We provide follow-up care for consumers after hospitalizations or emergency department visits	○	○	○	○

PERFORMANCE MONITORING

29. Does your main clinic generate performance measures to assess the quality of services listed below? If yes, how often?

Type of performance	*(Choose the closest answer for how often performance type is measured)*			
	Never	**Sometimes, but less often than quarterly**	**About quarterly**	**At least monthly**
a) Quality of preventive care (e.g., % of appropriate immunizations provided)	○	○	○	○
b) Quality of care for chronic or acute conditions (e.g., diabetes, asthma)	○	○	○	○
c) Costs (e.g., emergency department visits, hospitalizations, other service use, medications)	○	○	○	○

30. Please indicate whether your main clinic uses Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) or other regional or state data to monitor program performance or deliver care.

(Check all that apply)

☐ PSYCKES

☐ Regional Health Information Organization (RHIO)

☐ Other data sources (specify)

PROGRAM SUCCESSES AND CHALLENGES

31. To what degree has your main clinic successfully implemented the following aspects of an integrated care program to provide and coordinate physical health services for behavioral health consumers?

	(Rate degree of successful implementation.)				
Program component	**N/A *(Not intended to implement)***	**Not at all**	**Partially**	**Largely**	**Fully**
a) Care management and coordination of physical and behavioral health services	○	○	○	○	○
b) Clinic has a culture of treating the "whole person"	○	○	○	○	○
c) Screening for physical health conditions and risk factors	○	○	○	○	○
d) Providing other preventive services (e.g., immunizations)	○	○	○	○	○
e) Referrals to external health providers, including specialists	○	○	○	○	○
f) Sharing consumer health data among primary care and behavioral health providers within our clinic	○	○	○	○	○
g) Sharing consumer health data with providers or facilities outside our clinic	○	○	○	○	○
h) Sharing consumer health data with consumers (e.g., to motivate behavior change)	○	○	○	○	○
i) Tracking consumer health information over time (e.g., by registry)	○	○	○	○	○
j) Wellness services (e.g., smoking cessation, diabetes education)	○	○	○	○	○
k) Other (specify)	○	○	○	○	○

32. Below is a list of potential challenges to integration of physical health care in behavioral health clinics related to Health Homes. Please rate the severity of each challenge.

Challenge (related to Health Homes)	*(Rate severity of challenge)*		
	Not a challenge	**Minor challenge**	**Major challenge**
a) Connecting consumers to primary care services through the Health Home	○	○	○
b) Connecting consumers to specialty medical care through the Health Home	○	○	○
c) Connecting consumers to social services (e.g., housing) through the Health Home	○	○	○
d) Contacting referrals from the state (i.e., top-down referrals)	○	○	○
e) Enrolling eligible consumers into the Health Home	○	○	○
f) Finding providers within the Health Home who understand the needs of the consumers with SMI and treat them with respect	○	○	○
g) Meeting data collection and reporting requirements of Health Homes	○	○	○
h) Obtaining consent from consumers for health information-sharing	○	○	○
i) Sharing consumer health information with providers outside of our clinic	○	○	○
j) Other (specify)	○	○	○

33. *(If your clinic receives a **Primary and Behavioral Health Care Integration** (PBHCI) grant from SAMHSA, please answer the following question. **Otherwise, skip**.)*

Below is a list of potential challenges to the integration of physical health care in behavioral health clinics related to PBHCI . Please rate the severity of each challenge.

Challenge (related to PBHCI)	*(Rate severity of challenge)*		
	Not a challenge	**Minor challenge**	**Major challenge**
a) Connecting consumers to PBHCI-supported primary care services	○	○	○
b) Connecting consumers to PBHCI-supported specialty medical care	○	○	○
c) Connecting consumers to PBHCI-supported social services (e.g., housing)	○	○	○
d) Enrolling consumers into our clinic's PBHCI program	○	○	○
e) Hiring qualified staff to provide PBHCI services (e.g. primary care, wellness)	○	○	○
f) Sharing consumer health information with providers within our clinic	○	○	○
g) Sharing consumer health information with providers outside our clinic	○	○	○
h) Other (specify)	○	○	○

34. *(If your clinic bills **Medicaid** for providing on-site health physicals or health monitoring, please answer the following question. **Otherwise, skip.)***
Below is a list of potential challenges to the integration of physical health care in behavioral health clinics related to billing Medicaid for on-site health physicals or health monitoring. Please rate the severity of each challenge.

Challenge (related to billing Medicaid for on-site health physicals or monitoring)	*(Rate severity of challenge)*		
	Not a challenge	**Minor challenge**	**Major challenge**
a) Connecting consumers to primary care services when indicated by their health physicals or monitoring results	○	○	○
b) Connecting consumers to specialty medical care when indicated by their health physicals or monitoring results	○	○	○
c) Hiring qualified staff to provide on-site health physicals or monitoring	○	○	○
d) Maintaining sufficient volume of consumers to sustain staff required to provide health physicals or monitoring	○	○	○
e) Scheduling consumers for health physicals or monitoring in our clinic	○	○	○
f) Sharing consumer health information with providers within our clinic	○	○	○
g) Sharing consumer health information with providers outside our clinic	○	○	○
h) Other (specify)	○	○	○

35. **Now, please consider your clinic's overall efforts to provide or coordinate physical health services for behavioral health consumers.** Please identify your clinic's top 5 challenges and rank each from 1 to 5, where 1 = the most significant challenge.

(Rank only the top 5 and leave other rows blank.)

- ☐ Connecting consumers to primary care services
- ☐ Connecting consumers to specialty medical care
- ☐ Connecting consumers to social services
- ☐ Data reporting requirements / administrative burden
- ☐ Getting different provider types (e.g. primary care physicians and psychiatrists) to work together effectively
- ☐ Hiring or maintaining qualified staff to provide physical health or care coordination services
- ☐ Physical space for integrated care
- ☐ Recruiting or engaging consumers in primary care
- ☐ Reimbursement / financial sustainability
- ☐ Shared decision-making between primary care and behavioral health leadership
- ☐ Sharing consumer health information with providers within our clinic
- ☐ Sharing consumer health information with providers outside our clinic
- ☐ Transportation for consumers
- ☐ Others (specify) _____

FINANCING

36. Below is a list of federal, state, and local initiatives that may be influencing your clinic's ability to financially support integrated physical health care in your behavioral health clinic. Please indicate whether each of the following is either helping, hindering, or having no effect on financing your integrated care program.

	(Describe influence on your funding.)			
Federal, state, or local initiative	**Helping**	**Hindering**	**No effect**	**Don't yet know**
a) Medicaid expansion	○	○	○	○
b) Private insurance expansion (i.e., ACA insurance exchange)	○	○	○	○
c) Mental health parity legislation	○	○	○	○
d) Health Homes	○	○	○	○
e) New Medicaid managed care arrangements	○	○	○	○
f) Changes in Medicaid reimbursement rates	○	○	○	○
g) Other state Medicaid initiatives (specify) _____	○	○	○	○
h) State health or mental health authority initiative (specify) _____	○	○	○	○
i) Grants from foundations or other sources (specify) _____	○	○	○	○
j) Other (specify) _____	○	○	○	○

37. What are your primary concerns about funding your clinic's efforts to provide and coordinate physical health services for behavioral health consumers? What important services or resources are most difficult to support financially?

38. Briefly describe your long-term plan for financially sustaining your integrated care program. What sources of funding and program or infrastructure changes does your plan involve? How much of your plan have you already implemented?

39. What state policy changes could facilitate ongoing or improved delivery of integrated physical health services for behavioral health consumers?
(Check all that apply)

☐ Changes in reimbursement (specify)

☐ Changes in licensing requirements (specify)

☐ Coordination of initiatives (specify)

☐ Other (specify)

40. Please use the space below to tell us anything else that you would like us to know about your integrated care program.

Thank you for completing this survey! Your time is much appreciated.